The Public Health Nurse

Volume XXI May, 1929 Number 5

Tuberculosis Nursing for Public Health Nurses
Part II

Nurses from Many Lands
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Salaries of Public Health Nurses

The PUBLIC HEALTH NURSE

Official Organ of The National Organization for Public Health Nursing, Inc.

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The Lady With A Lamp

OLD landmarks are passing quickly in this changing world, and pilgrims to London will no longer be able to linger in a quiet, unpretentious street before a house bearing a tablet inscribed "Florence Nightingale, born 1820, died 1910, lived here."

No. 10 South Street, Park Lane, where Miss Nightingale spent the last forty-five years of her long life, has given way to the submerging tide of apartment houses. "The nicest little house in London" her sister, Lady Verney, called No. 10, and it held within its four walls at one time or another during these years distinguished visitors from many lands.

The old Burlington Hotel was Miss Nightingale's home before she moved to No. 10, and there she "held court" in the stormy years during which she labored with all the force of her imperious personality to drive home to a reluctant parliament, through the reform measures drawn up by Sidney Herbert, the lessons learned in the Crimean War. While she lived at the Burlington an apartment in Kensington Palace was prepared and offered by Queen Victoria to Miss Nightingale as a residence. But in those years of overwhelming work, all she wanted was quiet and "freedom from things" and the honor was declined.

It was the South Street house that has been so nearly and dearly connected with Florence Nightingale's nursing interests. Here she gave audience and warm welcome, always carefully planned—her ill-health, as she said, obliged her "to make Life an Art"—to nurses from the high to the low, always exercising in her exquisite hospitality "the methodical and critical habits which she had practiced in larger spheres." Miss Nutting, who once visited her, gives a charming picture. Miss Nightingale was then very old, but her eyes were still bright and blue,

Scene from Reginald Berkeley's Play—at Embley Park in 1845. Reproduced from The Illustrated London News.

her cheeks flushed with clear rose color, set off by the soft kerchief covering her white hair. Her beautiful hands and her voice, clear, full and sweet, were as noticeable as in her youth. Miss Nutting remembers the house with its air of distinguished simplicity very much as it is described in Sir Edward Cook's "Life." Miss Nightingale's own room was upstairs at the back of the house, with wide windows and flower balconies looking into the greenery of a London garden. One of the first things the visitor's eye fell upon was a lovely portrait of Sidney Herbert, a copy of the drawing by George Richmond. It was a "book-

ish" room, and yet its whole atmosphere was of delightful freshness, order and tranquillity—that ideal air of a sick room Miss Nightingale conveys in her "Notes on Nursing." Here, during her last long years of confinement she lived graciously, interested almost to the very end in "everything except what was trivial." Persian kittens (there must have been many generations) and birds gave a homely touch. The "Dicky-Bird Society" was given the benefit of her close study of the dietary habits of birds.

The New Play

Coincident with the disappearance of the London house, London has, however, been reminded this year of one of the greatest of the notable women in her long civic history. "The Lady with a Lamp" by Reginald Berkeley, "one of the interesting plays of our time," to quote the *Manchester Guardian*, was produced this winter in London. Before giving some of the encomiums on the play that have appeared in British papers, we would like to recall a page of our own history.

Seven years ago is somehow a long time in our swift, modern and American moves from one interest to another. Few people will now remember that during the year of the Florence Nightingale Centenary, 1920, a prize of $500 was offered by the Central Committee on Nursing Education for the best play by an American author based on incidents in the life of Florence Nightingale. The committee in charge of the competition was appointed by the N.O.P.H.N. and the details were carried out in the organization office. The committee was composed of Mrs. Minnie Maddern Fiske, Miss Marylka Modjeska, Miss Alice Beer, Miss Lillian D. Wald. Twenty-eight plays were submitted from many sources. The prize was awarded to Mr. Harold Newcomb Hillebrand of the Department of English, University of Illinois. Honorable mention was given to Mrs. Harry Fielding Reid of Baltimore. It was hoped that Mr. Hillebrand's play could be produced on a New York stage but the tentative negotiations were never completed. This delay unfortunately prevented the immediate publication of the play in its original form. The only copy is now in the N.O.P.H.N. archives. Mrs. Reid's play was published by the Macmillan Company in 1921 and is still available.

To return to Reginald Berkeley's production, "The Lady with a Lamp." Both *The Nursing Times* and *The British Journal of Nursing* speak with admiration and appreciation of the sympathy with which the author has dealt with a subject full of perils to the dramatist, and praise the play as a brilliant and skillful presentation.

Miss Nutting writes: "Reginald Berkeley has about as penetrating an understanding of Florence Nightingale as Sir Edward Cook himself. I have been told how the latter's admiration and respect grew as he studied her life and it took hold of him as it were.

"The playwright speaks of something Florence says as 'a foretaste of the *blasting irony* of later life.' Talking with Purveyor Bamford about the regulations standing in the way of getting her supplies,

> Florence: '. . . The army is only a matter of common sense.'
> Bamford: '. . . The army's a matter of strict unquestioning obedience.'
> Florence: 'I am glad you realize there's a difference between the two.'

"Lord Palmerston is well drawn. 'No amount of good-will can make up for lack of knowledge. The opportunity is half the battle. But the ability to take advantage of it is the other half.'

"Florence saying, 'Women want the same freedom as men to direct their own lives and use their own brains,' and Palmerston replying, 'There will be a woman in the Cabinet in 1930. You've started them'—give the theme, the motif."

The *Manchester Guardian* says:

> Mr. Berkeley has done more than raid history for a first-rate part: he has let himself be seized by that part and carried on its greatness to write the best piece of work that he has given us. The chronicle play is

here seen in its most extensive form, since we follow the life of Florence Nightingale over more than sixty years, only one scene showing her at Scutari with lamp in hand and toiling amid the agony of medical misrule. Episodes such as love interest, the jealousy of Lady Herbert, which would dominate a smaller play, are kept in subjection to the central purpose, which is to show the path-maker for the modern woman, a Maid of Scutari, who broke down shame and barriers and unmasked pretenders as bravely as did Joan before her. To this view of the great fanatic Mr. Berkeley is efficiently faithful.

We learn that Gilbert Miller will produce Captain Berkeley's play in this country, with the English actress Gwen Ffrangcon-Davies (who appeared in the London cast) as the heroine. The younger generation, to many of whom even the name of Florence Nightingale is unfamiliar, will have an opportunity to see in this fine dramatization a thrilling page of nursing history.

"PIONEERS, OH, PIONEERS!"

Current magazines are full of articles deploring the rapid mechanization of our civilization, "group standardization" and other consequences of our times. True enough in much of American existence. But that there are vast reaches of community life in these United States still unaffected by these supersophistications is just as true. In this number we present two articles on rural conditions in widely separated sections. Nothing standardized is portrayed here—except perhaps their unstandardization from the higher development point of view. And these pictures could be duplicated in other states and other countries.

It is into places and living such as these that our rural nurses go—often the forerunners of other healing agencies—bringing with them the keys of their calling, knowledge, skill, sympathy, imagination, courage, common sense—"And the desert shall blossom as the rose." Honor to the pioneers.

All those interested in public health nursing will be glad to know that Miss Beard, who has been so closely associated with this movement, is making it possible for all of us to share in her wide experience and her thinking upon many phases of public health nursing.

Of particular interest is the last chapter of her forthcoming book, printed in this number of the magazine, which gives her own personal opinion as to the future outlook. Many will agree with her about feeling that more emphasis should be laid upon the fact of one nursing organization. At the present moment there really *is* only one professional nursing organization in to which should increasingly be pooled all of our professional interest and activities as such.

However, there is an equally strong feeling on the part of many, of the continuing need of national organizations representing such special interests as nursing education and public health nursing. These are not professional questions as such, nor are they of concern only to the professional group; therefore the general agreement with Miss Beard as to the need of emphasizing one professional nursing organization does not necessarily mean the elimination of other organizations in which nurses play an important part.

Fruits in the Diet

By Margaret S. Chaney

Professor, Food Economics and Nutrition, Kansas State Agricultural College

Fifth in the series on Special Diets. Previous articles are: "Cereals—Main Stay of a Good Diet" by Williedell Schawe—November, 1928; "The Diet of Cardiac Patients" by Louise O. Canham—December, 1928; "The Diet of Diabetic Patients" by Kathleen M. Lewis—January, 1929; "The Mineral Requirements of the Body" by Martha Koehne—March, 1929.

THE old saying "an apple a day keeps the doctor away" is more truth than fiction as recent experimentation has conclusively demonstrated. But not only the apple has this power for health; today fruits, both raw and cooked, fresh and dried, have earned a place among the foods advised in the daily diet when health and vigor are desired.

The reasons for the use of fruit are many, fruits and vegetables alike serving several functions more efficiently than do other foods. Probably of primary importance is the vitamin content of fruit—the presence of those substances concerning which little is known but which are conceded to be essential for a state of good nutrition.

Vitamin B, which scientists now believe consists of three fractions, is widely distributed among plants and is found in the root, tuber, stem, leaf, seed and flower as well as in the fruit. As this vitamin is not destroyed by ordinary cooking processes the method of preparing and serving fruit does not have to be considered; however, since it is water-soluble there is danger of its loss when the food is soaked in water and precautions should be taken to use the liquor when the food is cooked. Also since vitamin B is destroyed by alkalies the use of soda in cooking should be avoided when conservation of this factor is desired.

ORANGE JUICE BEFORE BREAKFAST

Because of their effect in stimulating the appetite, fruits are often recommended by doctors. Experiments made upon infants by Byfield, Daniels and Loughlin[1] showed that 15 c.c. of orange juice, the customary amount given daily to each baby in their clinic, often resulted in stationary weight; when the amount was increased to 45 c.c. a marked stimulation of growth was noted. This was proven to be due to the vitamin B in the orange. Cowgill[2] working with adult dogs also demonstrated the relationship of vitamin B to appetite and ascertained the amount of yeast, a vitamin B-rich food, necessary for the consumption of sufficient food for the maintenance of body weight. Less yeast resulted in loss of appetite and in weight decrease. Since anorexia or loss of appetite is a common complaint among children and adults today and since fruits are known to be good sources of B, it seems wise to recommend their use in liberal amounts. A glass of orange juice given half an hour before breakfast often works wonders with the appetite of a non-hungry child.

Vitamin C, the antiscorbutic substance, is likewise found in fruits, especially the citrus ones. Differing from the other water-soluble factor B, vitamin C is not stable and is easily destroyed by heating in the presence of oxygen and by prolonged exposure to air; for this reason fresh raw fruits are recommended for daily use. The child early in life should be given orange or tomato juice, especially if he is receiving heated milk as his sole food. And since the amount of vitamin C in breast milk depends largely upon its inclusion in adequate amounts in the mother's diet it is advised that both breast-fed and bottle-fed infants receive an antiscorbutic. During the second and often during the first month of the baby's life orange juice may be fed. In place of orange, tomato is

often used and since in commercial canning little oxidation is permitted to take place the canned tomato is found to be an excellent source of vitamin C.

Orange juice, concentrated in vacuum at a low temperature has likewise been found [3] to retain practically all of the vitamin C property of the original fruit and today the British Navy uses Califorange, a commercial juice, as its antiscorbutic food on ships of war. Lemons, grapefruit, apples and bananas as well as other raw fruits and vegetables are a source of supply of vitamin C and should be eaten as a protection against a chronic tired feeling, aching joints, irritable gums, hemorrhages, and scurvy.

Since vitamins A and D are found plentifully in whole milk, eggs, butter and cod liver oil, foods normally included in the diet of the child and, with the exception of cod liver oil, in that of the adult, it does not seem necessary to consider the potency of fruit in the fat-soluble factors. It will suffice to say that A is found in considerable amounts in many fruits while D is present in negligible quantities.

MINERAL CONTENT OF FRUIT

Another important reason for the inclusion of fruits in the diet is their mineral content. Calcium, phosphorus, iron, magnesium, sodium, sulphur, potassium, chlorine, iodine and other inorganic substances all have their functions in regulating body activities and must be supplied in sufficient amounts if the tissues, bones and blood react normally. The effect of minerals in fruits on the metabolism of the body has been given considerable attention.

In a study on the relationship of oranges to the utilization of calcium, phosphorus and magnesium by the growing child [4] it was found that the addition of this fruit to the diet resulted in a definitely larger retention of the three minerals—much more than could be accounted for by the salts present in the orange. Bananas will accomplish the same effect as shown by Eddy [5]. Whether or not this is a property of specific fruits or of all varieties has not been proven but surely it is wise to profit by knowledge already obtained and include in the day's menu foods shown to favor an optimal body condition.

With the exception of the dried forms, fruits are not rich in iron, but since small amounts of this element have a remarkable effect on health and since fruits contain other substances which aid in the utilization of iron, they are of importance in the daily diet. Peterson and Elvehjem[6] have recently made studies which indicate that the juice of tomato and orange contains a proportionately smaller amount of iron than does the whole fruit. These data should change the present day policy of feeding strained fruit juices to children; as early as possible pulp as well as juice should be fed.

BLOOD REGENERATION

Of much interest of late have been the studies made on foods as related to their blood regenerative powers. While it is an assumed fact that fruits are not valuable as blood builders Whipple and his co-workers[7] have found that some varieties are efficient in this respect. Apricots, peaches and prunes and to a lesser extent apples and raisins function as blood regeneration in simple anemia whereas black raspberries have no beneficial effect. The cooked apricots, peaches, and prunes, either dried or fresh, ranked equally with spleen, heart and pancreas in this respect, and were far superior to dairy products. The fact that the beneficial influence of the fruits was not in proportion to their iron content favors the opinion of Whipple that some other factor than iron, probably inorganic, is responsible. Whatever the cause, the favorable effect of these fruits indicates their value as a food, and the need for their frequent consumption.

BALANCING THE DIET

In planning a balanced diet it is necessary to consider the relation of acid-forming to base-forming elements. Foods when burned in the body yield a residue or ash, the reaction of which

depends upon the kind of food eaten. Meat, eggs and cereal products produce an acid ash whereas milk, vegetables and fruits, with the exception of prunes, plums and cranberries, are basic. Since the blood and other tissues of the body are slightly basic in reaction and since the predominance of acid in the diet of meat, eggs and cereals will upset this balance and cause acidosis, it is essential that base-forming foods be supplied in liberal amounts. Often citrus fruits because of their tart taste are considered an acid-ash food but to the contrary they increase rather than decrease the alkaline reserve of the blood. Blatherwick and Long[8] found that extremely large amounts of orange juice caused no harmful effects. Amounts up to 2,400 c.c. or about 10 cups of juice were fed daily and it was impossible to overreach the organism's ability to oxidize the citric acid; the urine was alkaline and contained less ammonia than usual, both of these reactions being desirable for health.

LAXATIVE PROPERTIES

As a laxative, fruits occupy an important place among foods. Constipation, one of the most common ailments of today, may be traced often to improper food habits—a diet composed of concentrated refined food stuffs. As a source of bulk and as a stimulant for the flow of digestive juices fruits are valuable and when eaten in liberal amounts, along with vegetables and whole grain cereal products, will ordinarily correct improper elimination. Often when an infant is weaned from the breast and cow's milk is substituted, a condition of constipation results. In such a case orange juice or prune pulp may remedy the disorder.

The average healthy person should, it is plain to see, include in his daily diet fruits, one preferably raw and citrus, one cooked. These have been shown to be valuable because of their vitamins and minerals, their laxative qualities, their aid in maintaining an acid-base balance in the body. But for the sick as well as the healthy person fruits play an important rôle and in many disorders are especially prescribed by the physician.

An anti-constipation diet should, according to one authority, contain two and one-half pounds of fruit and vegetables; this addition, it is suggested, can be accomplished by the use of extra fruit for breakfast in addition to fruit juice, and by the use of fruit in salads and desserts. Oranges, figs, prunes and rhubarb are especially desirable as laxatives.

OTHER USES

Bananas are satisfactorily used in the treatment of celiac disease. According to Johnston[9] six cases of scurvy were cured when bananas were fed as 40 per cent of the total calories in the diet. This fruit is also recommended as a valuable addition to the diet of children whose appetite must be stimulated during recovery from disease. In all cases this fruit should be ripe, as demonstrated by the brownish peel and a sweet mellow flavor.

Fruits occupy a large place in the reducing diet since they are largely water and cellulose and since they contain a liberal supply of vitamins and minerals, two food stuffs likely to be neglected in an anti-fat regime. The carbohydrates found in fruits are of low concentration and are of value in the oxidation of fats, since in the absence of the former, fat is incompletely burned and the acetone type of acidosis may result. According to Sansum and Bowden[10] for each pound of flesh lost the patient must eat at least one pound of starch and sugar.

In the acid-ash type of acidosis an abundance of basic foods must be eaten to restore the alkaline balance of the body. Oranges, lemons, apples, muskmelons and bananas have been found to be effective in this disease. A relationship between high blood pressure and acid-ash foods has been proven by Sansum and Bowden[11]. Fifty cases of high blood pressure were treated with an alkaline-ash diet and in 90 per cent of the cases the blood pressure fell on an average of from 40 to 50 points. Only the patients with marked sclerosis of the blood vessels and

excessive kidney damage failed to respond satisfactorily.

In the treatment of malnutrition among children the addition of fruit to the menu is found to be beneficial. Often an insufficient quantity of food is the cause of this common disorder and fruits as appetite stimulators play a large part in restoring the child to normal. Investigations made on the use of orange juice as a mid-morning lunch for the underweight child [12] indicated that it results in a marked stimulation to growth. The fact that it does not retard the child's desire for food at meal time is a good argument for its use rather than milk, and in many schools today orange juice can be obtained, freshly bottled, for a mid-morning lunch.

Figs as well as oranges were found by Morgan and Hatfield [13] to increase the alkaline reserve of the blood of malnourished children and to stimulate growth. A probable correlation between certain types of malnutrition and a low alkaline reserve of the blood plasma was indicated, a rise in carbon dioxide combining power of the blood paralleling a gain in weight.

Because of its many important functions fruit is a valuable asset in the diet during sickness and health. Without fruit life would hardly be worth living.

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OUT-PATIENT FOOD CLINICS

"Old grads" whose memories of dietetics as taught in student days only recall calories, formulæ, and special trays, will envy some of the student nurses at the Massachusetts General Hospital who are receiving instruction in how to adapt special diets to home conditions, to limited budgets, and untrained minds. About 17 students, at the rate of one every three weeks, are placed under the supervision of the Hospital's out-patient food clinics where they are given an idea of the purpose of the clinics, observe the work of the dietitian, attend conferences with patients and assist with weighing and checking up on old cases. The assistance includes diabetic, epileptic and general case experience. The three purposes in including this valuable experience for students are:

That they may see how very important diet has become in the treatment of disease and the maintenance of health.

That they may realize how carefully and patiently many of these patients must be taught; that it is just a waste of time to say to a patient: "You should be on a diabetic diet, cut out your sugars and starches." They also come to realize that diet must be directed by a physician.

That they may realize that the medical and nursing care in the usual interpretation of those functions are only a small part of the service which the community renders to a large part of its population limited financially and limited in health intelligence.

Nurses From Other Lands

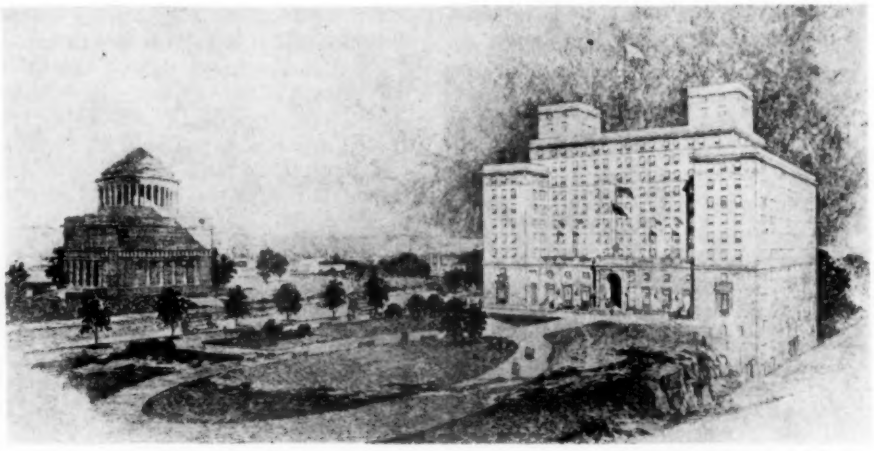
By Katharine Faville, R.N.

"Ships coming in from the whole round world, and going out to the whole world."

NURSING, as a profession, has never been aware of the boundary lines of nations in its progress. The best that one country could develop was borrowed and improved upon by the next, who in turn cut professional patterns to lend its other neighbors.

This is particularly true of the United States. From the nurses of other lands we first learned the intricacies of this profession of nursing—taking their best, freely offered, adapting and developing it as the needs of this young country changed and grew. During these past years many of the older systems of nursing have broken abroad, compelling reorganization to fit with modern thinking, and exceedingly interesting pieces of work are now under way. We of the United States need to watch these foreign experiments carefully, seizing every opportunity to pool our experiences, to work together on the development of common principles, to learn from each other's mistakes and wisdom. Eagerly we seek to learn their best, that we may adapt it to our own peculiar problems; carefully we must see, in return, that we give them only what is good.

Students from abroad are coming to this country in increasing numbers, among them nurses, who usually wish to get a varied experience in several parts of the United States, many spending some of their time in New York City. During the school year 1928–1929, twenty foreign students registered in the Department of Nursing Education at Teachers College. These differed greatly in their specific needs and interests, but were markedly similar in their thirst for practical knowledge which could be carried back to apply to their home problems.



Courtesy of the Rockefeller Foundation

International House

Some will go home to administer hospitals, or teach in newly developed training schools. Others expect to develop public health nursing services—visiting nursing, hospital social service, municipal health work—pioneers all, makers of nursing history in their parts of the world. If anyone thinks that adventure has ended and that nursing is growing standardized and mundane, let her listen to the stories

these nurses have to tell—whole countries to be nursed and given health protection, governments to be educated to the health needs of their people, age long superstitions to be overcome, their responsibilities so great as to be equalled only by their courage.

Does one hear that nursing has become commercialized, and that the old spirit of sacrifice is gone? The stories of the struggles being made by these nurses to fit themselves for the stupendous undertakings that lie ahead, so that they may give their best, and that best be adequate all deny it. An instructor discovered that one of her foreign students was trying to read every book on the long bibliographies given out in class for reference because on return home there would be no libraries of health literature, no professional books nor magazines available. The salary accepted by this nurse would supply only the bare necessities of living. Professional isolation was anticipated and prepared for—in no spirit of self pity—but with an acceptance that filled the observer with a mixture of heartache and great admiration. In many instances the annual incomes of these nurses will be no greater than the monthly salary of some of our American nurses.

Equally earnest was the nurse who, speaking English, Dutch, German, and French, when she found herself assigned for four months of field work to an Italian district, employed a tutor nights to teach her to speak Italian, "so that I can talk intelligently to the mothers and understand their points of view," she explained.

Registered for courses in training school administration and teaching in schools of nursing are two students from Brazil, one from Denmark, two from England, one from Finland, one from Holland, two from Poland, one from Turkey, and one from the Philippines. Of those whose primary interest is in public health nursing one is from Greece, one from Holland, two from Ireland, one from Japan, two from the Philippines, one from Spain, and one from Turkey.

Great effort is being made to adapt the courses of study to individual needs, both in theory and practice. Field work is made available by various city organizations, the Henry Street Visiting Nurse Service, East Harlem Nursing and Health Service, and many of the city training schools coming forward with great generosity to help.

Many of these nurses live at International House, which was given several years ago by Mr. John Rockefeller for the use of foreign students in New York City. Built on Riverside Drive on a prominence above Grant's Tomb, commanding a wide view of the Hudson River, it offers a comfortable home to these visitors from all parts of the world, at prices which their purses can afford. A small number of American students also have the privilege of living there, who with the staff of the house, help to make the students' social and professional adjustments easier. The hospitable and friendly atmosphere of International House is well known throughout the city, with lecturers from other lands, art exhibits, musicales, and parties scheduled to fill all free moments. The stunt parties given by the various foreign groups are always especially entertaining, and eagerly attended by all who have the good fortune to be invited.

Special courses in English are offered at Columbia University as well as many lectures by American authorities, with the aim of presenting our best thought to these students in language easily understood. The students themselves contribute much to the enrichment of life for Columbia's great student body—bringing to the classrooms enticing glimpses of the customs and minds of other lands and days, widening our provincial horizons to include the hopes and needs of other continents, affording opportunity for friendships that will often be among life's richest. America gives much to these students who come to her schools—but she gains, in ways that are often immeasurable, far more than she gives.

Program—Congress of the International Council of Nurses—Montreal, Canada

Founded in London, July, 1899

President—Nina D. Gage, R.N., M.A., United States.
First Vice-President—Clara D. Noyes, R.N., United States.
Second Vice-President—Jean I. Gunn, R.N., Canada.
Treasurer—E. M. Musson, C.B.E., R.R.C., S.R.M., Great Britain.
Secretary—Christiane Reimann, R.N., M.A.

July 8, 2 p.m.—General Session—*Chairman: Miss Nina Gage, President, International Council of Nurses.*

President's Address.
Report of Grand Council, Officers and Committees.

8 p.m.—Opening Session—*Chairman: Miss Nina Gage.*

Addresses of Welcome: The Governor General of Canada—The Archbishop of Montreal—The Premier of Quebec—The Mayor of Montreal—The Chancellor of McGill University—President of the Canadian Medical Association—President of the Canadian Nurses' Association.

July 9, Morning—General Session—*Chairman: Miss Clara D. Noyes.*

Roll Call by countries.

Reports of affiliated organizations (in order of affiliation):
The National Council of Nurses of Great Britain.
The American Nurses' Association.
The Nurses' Association of Germany.
The Canadian Nurses' Association.
The Danish Council of Nurses.
The Nurses' Association of Finland.
The Nosokomos, Holland.
The Trained Nurses' Association of India.
The New Zealand Trained Nurses' Association.
The National Federation of Belgian Nurses.

Exchange Scholarships—Miss Alice Lloyd Still, London.

Afternoon—Meetings of Sections.

NURSING EDUCATION—*Chairman: Miss Lillian Clayton, President, American Nurses Association.*

The Preparation of a Curriculum—Dr. E. S. Ryerson, Secretary, Faculty of Medicine, University of Toronto.

Trends and Development in Vocational Education—W. W. Charters, Ph.D., Professor of Education, University of Chicago, U. S. A.

The Community Need in Relation to the Education of the Nurse—Mlle. Chaptal, President, National Association of Trained Nurses of France.

PRIVATE DUTY—*Chairman: President, The Nurses' Association of Germany.*

The Status and Problems of the Private Duty Nurse—Speakers from Asia, Australasia, Africa, Europe, America.

PUBLIC HEALTH—*Chairman: President of New Zealand Trained Nurses' Association.*

Developments in the Public Health Field—Dr. G. B. Roatta, Director of Dispensaries, Florence, Italy.

The Red Cross Nursing Program—Mrs. Maynard Carter, League of Red Cross Societies.

Evening—General Session—*Chairman: Mrs. Bedford Fenwick, Founder, International Council of Nurses.*

The Watchword—Mrs. Bedford Fenwick.

Introduction of Newly Affiliated National Organizations.

Greetings from pioneer members—Miss Lavinia L. Dock, United States—Miss Margaret Breay, Great Britain—Miss Mary A. Snively, Canada.

The Future—Miss M. A. Nutting.

July 10, Morning—Round Tables.

The Need of Education in Mental Nursing in the General Nursing Curriculum—*Chairman, Miss S. C. Hearder, London, England.*

Utilization and Organization of Teaching Services in Various Public Health Activities not under School Control—*Chairman, Mlle. Cecile Mechelynck, Belgium.*

Economic Aspects of Nursing Education and Nursing Services—*Chairman, Miss Nellie X. Hawkinson, U. S. A.*

Specialized Training for Private Duty Nurses—*Chairman,*

The Public Health Nurse and Social Work—*Chairman, Miss Alma C. Haupt, U. S. A.*

Text and Reference Books for Nurses—*Chairman, Miss Zefira Majdrakova, Bulgaria.*

The Place of Preventive Medicine in the Curriculum of the School for Nurses—*Chairman, Miss J. Romanowska, Poland.*

Staff Education—*Chairman, Mr. Kuo Jung Hsein, China.*

Afternoon—General Session—*Chairman—Miss Nina Gage.*

University Schools of Nursing—Miss Annie W. Goodrich, U. S. A.

Leadership—(To be appointed.)

The Nurse as a Citizen—Sister Bertha Wellin, Sweden.

July 11, Morning—General Session—*Chairman: Miss Jean I. Gunn.*

Reports of Affiliated National Organizations (In order of affiliation).
The Nurses' Association of China.
The National Association of Italian Nurses.
The Norwegian Nurses' Association.
The South African Trained Nurses' Association.
The Bulgarian Nurses' Association "Florence Nightingale."
The National Association of Nurses of Cuba.
The National Association of Trained Nurses of France.
The National Council of Trained Nurses of the Irish Free State.
The National Council of Polish Professional Nurses.

Reports of National Organizations affiliating at Montreal Congress.
Reports of Associate National Representatives.
Reports from other countries.

Round Tables.

Maternal Care—*Chairman, Miss Margaret Breay, Great Britain.*

Administration of and Instruction in School Wards in Hospitals not under School Control—*Chairman, Mlle. Chaptal, France.*

Red Cross Nursing—*Chairman, Mrs. Maynard Carter, League of Red Cross Societies.*

New Ideas and Devices in the Nursing Care of the Patient—*Miss Nellie Healy, Irish Free State.*

Afternoon—Meetings of Sections.

NURSING EDUCATION—*Chairman, Miss Lillian Wu, China.*
Legislation as Related to Nursing—Miss E. M. Musson, Great Britain.
State Supervision in Schools of Nursing—Miss Adda Eldredge, U. S. A.
Organization of a Post-Graduate Study—Miss Cox-Davies, Great Britain.

PUBLIC HEALTH—*Chairman, Mlle. J. Hellemans, Belgium.*

The Citizen in Relation to the Public Health Program, Canada—Dr. Helen Reid, Canada.

The Study of the Normal Child as a Preparation for Public Health Nursing—

Physical Aspects—Mlle. Grenier, France.
Mental Aspects—Miss Winifred Rand, U. S. A.
Discussion opened by Miss Mitchell, South Africa.

PRIVATE DUTY—*Chairman, Miss Cornelia Petersen, Denmark.*

Developments in Private Nursing—Miss Isobel Macdonald, Great Britain.
The Financial Aspects of Medical and Nursing Services—Miss Elizabeth Fox, U. S. A.

Evening—General Session—*Chairman: Miss Mabel Hersey, Canada.*

The Scientific Method in Social and Health Work—Dr. Julius Tandler, Professor of University of Vienna and Health and Welfare Commissioner of Vienna.

The World's Health—Dr. J. L. Biggar, National Commissioner of Canadian Red Cross Society.

July 12, Morning—Round Tables.

The Coöperation Between Sister Tutors and Ward Sisters in the Training of the Student Nurse—*Chairman, Mrs. L. L. Bennie, South Africa.*

Nursing in Relation to Mental Hygiene from the Standpoint of the Community—*Chairman, Miss Katharine Tucker, U. S. A.*

Health of Student Nurses—*Chairman, Sister Andrea Arntzen, Norway.*

Community Organization for Health Work—*Chairman, Miss H. L. Pearse, Great Britain.*

Government Nursing Services—*Chairman, Miss Elinor D. Gregg, U. S. A.*

Recreation and Other Activities of the Student Nurse—*Chairman,*

The Purpose, Scope and Arrangement of Practical Field Work in the Training Course in Public Health Nursing—*Chairman, Miss Eunice Dyke, Canada.*

University Relations in Schools of Nursing—*Chairman, Miss Mabel F. Gray, Canada.*

In What Cases can Visiting Nursing be Substituted for Private Duty Nursing—*Chairman, Miss J. Serton, Holland.*

Afternoon—General Session—*Chairman: A representative of the National Association of Italian Nurses.*

Rural Nursing—Miss Nikica Bovolini, Jugoslavia—Miss Alexandra M. Wacker, Hungary—Miss Mary K. Nelson, U. S. A.—Miss Elizabeth Smellie, Canada.

July 13, Morning—General Session—*Chairman: Miss Nina Gage.*

Resolutions from Sections; from Round Tables.
Report from Grand Council; General Business Session.

Evening—General Session—*Chairman: Miss Nina Gage.*

The Interdependence of Nations—Hon. R. B. Bennett, Leader of the Opposition, House of Commons, Canada.

Addresses of Farewell—

Asia—Miss C. F. Slater, Former Secretary of Trained Nurses' Association of India.
Australasia—President or representative of New Zealand Trained Nurses' Association.
Africa—Mrs. L. L. Bennie, President, South African Trained Nurses' Association.
North and South America—President or representative of the National Association of Nurses of Cuba.
Europe—Representative of the Nurses' Association of Finland.

Films on nursing subjects will be shown daily during the Congress. Exhibits will be shown at Congress Headquarters.

Registration daily from 9 A.M. to 10 P.M. beginning July 5th, at Congress Headquarters, Montreal High School, University Street.

Official Information Bureau at Congress Headquarters. The Chairman of the Committee on Arrangements is Miss Mabel Hersey, Superintendent of Nurses, Royal Victoria Hospital, Montreal.

Delegates will receive complete program and information at time of registration. This will include information of interesting places to visit in and near Montreal; also available restaurants. Meals outside hotels need not cost more than 50–75 cents for breakfast, 75 cents for lunch and $1.00 for dinner, and may be had for less.

Room Reservations.

Rates for rooms are as follows:

Hotels—Three persons per room, $9.00 per room per day.
Four persons per room, $10.00 per room per day.

Small Hotels—$2.00 to $2.50 per person.

Rooms in private houses, boarding houses and Y.W.C.A.—$1.50 to $2.00 per person.

Convents will be able to care for quite a number at $1.25 to $2.00 per person for bed and breakfast.

Hotel accommodation is being *very rapidly reserved.* When sending applications please state whether you would be willing to accept such accommodation as the committee can arrange. Application should be addressed to Miss E. Frances Upton, Royal Victoria Hospital, Montreal, Canada, and should state name, address and position of applicant.

Transportation.

Convention rates of fare and one-half will be authorized on the Identification Certificate Plan, distributed through the state chairman. (See page 133, March PUBLIC HEALTH NURSE.) *All tickets* must be validated by a ticket agent at Montreal before the return journey is commenced.

Nurses should reach Montreal by the morning of Monday, July 8, as the first meeting is at 2 P.M. The "Nurses Special" will leave the Grand Central Terminal, New York City, Sunday evening, 8:40 P.M. Eastern Standard Time, arriving in Montreal 6:58 A.M. July 8, and stopping at various points en route. Further information may be had from Mr. W. F. Sheehan, General Agent, Passenger Department, The Delaware and Hudson Company, 23 West 42nd Street, New York City.

Caroline Garnsey, Room 1641, 370 Seventh Avenue, New York City, is National Chairman of Transportation. *Information relative to post-convention tours* may be obtained from her.

The Hospitality Committee of the three national nursing organizations of the United States has prepared suggestive outlines of post-convention tours in the eastern, western or southern states, of interest to nurses. Write Miss Florence Johnson, American Red Cross, 598 Madison Avenue, New York City, for information on points of interest and rates.

The Hospitality Committee of the Manitoba Association of Registered Nurses, 753 Wolseley Avenue, Winnipeg, Manitoba, cordially invite nurses attending the International Congress of Nurses to "take a holiday where everything is different"—a trip up Lake Winnipeg to historic Norway House, or a trip to the North via the new Hudson Bay Railway. Visits to institutions and organizations in order to become acquainted with the nursing services of the province can be arranged by the Hospitality Committee.

A True Tale

By One Who Knows

We detachments steady throwing
Down the edges, through the passes, up the mountains steep
Conquering, holding, daring, venturing as we go the unknown ways.
Pioneers! O pioneers!

WHEN foreign visitors come to America to study the work being done in public health, they are always overwhelmed by the enormous resources in the public health field. They are taken to the cities where they see well organized visiting nurse associations, city health departments, clinics of all sorts open to everybody, well-equipped hospitals with hundreds and thousands of beds for charity cases, and they say, "Well, this is all very wonderful but in my poor little country these things do not exist. We have few of these aids to bettering the conditions of our people." Yet, actually, there are in this country many localities where conditions are quite as appalling as regards poverty and ignorance and lack of working facilities as in any of the European countries.

The public health nurses who go to work in these sections are as truly pioneers as the people who went out in the early days to the West to clear the forest and build up the communities we know today. Perhaps the conditions in the southern states are as difficult as any in the country, although there are portions of the West where the situations are equalled. In the South the situation is a little complicated by the mixture of population, since activities for white and negro must be carried on side by side but entirely separate. In the South the distribution of negroes and whites is unequal. Certain sections of each state will have a greater number of negroes than whites, while in other sections, usually industrial, the whites will predominate.

"The Independent Republic"

As an example of what the public health nurse encounters, I would like to tell the story of a nurse who went in to a so-called white county in one of the southern states. This county is so situated geographically that it is cut off from the rest of the state by rivers. For a long time these rivers had few bridges and contact with the rest of the state was very slight. Indeed the county became known as the "independent republic." It is a large county, a great deal of which is swamp land. The crop mainly cultivated is tobacco. The people, with the exception of those who live in the county seat and one or two small villages outside, are scattered over this large territory, living in one-room shacks sometimes isolated from others by a distance of miles. These one-room shacks are built of logs with mud for plaster, or of rough boards. Most of them have no windows, only wooden shutters, which are closed at night or in the winter to keep out the cold. A fireplace at one end furnishes the means of heating the house and of cooking the food.

Isolated as they have been for many years from the rest of the world, these people are illiterate and poor. None of the advances that have been made in the West have been made here. The children are far away from the schools, there is no compulsory attendance law, the parents have had no education themselves and can't see the use of it, so that few children are sent to school. The knowledge of food that has become so general in the country at large has not reached these people and the main diet is "hawg meat" and hominy. Few have any sort of garden but plant their crop of cotton or tobacco right up to the back doorstep.

A Pioneer Job

In this particular county, a public health nurse was employed in 1924. She found a home demonstration agent and a farm agent who were doing what they could to educate the people on agriculture and in the preparation of

foods, but there had been no specific health program before her arrival. There was no county hospital and no county poorhouse. Immediately she found herself the recipient of all kinds of calls from people who had some interest in the work she was starting. Many of these calls were really for social service but in the rural districts the nurse must be not only a public health nurse but a social service worker.

The nurse found in the county many children who were crippled but whose parents had no knowledge of the fact that there was any help for them. Through the State Clinic for Crippled Children it was possible to secure care for the majority of these crippled children but the great difficulty was to get the parents to consent to such care. Many of them had never been more than a few miles from home, most of them thought of a hospital as a place where you went to die and the common thing for the mother to say when the nurse approached her in regard to having her crippled child taken care of was, "Wal, likely he'd die and I'd rather have him like he am than daid." It has taken several years of education from the nurse to make these people realize that their children can go away to the hospital and come back normal.

Sometimes after the correction of the defects of a crippled child one reaches the place where the child must have some special apparatus in order to get the benefit of the operation. Here again the nurse finds herself in difficulty, for the majority of these parents, however hopeful they have been of being able to provide the money, when the time comes they find they have not got the wherewithal to pay for the brace necessary to hold the child's legs straight. The nurse must decide whether or not she can appeal to the county for help. Usually she does and in many cases is able by securing gifts from public spirited individuals to make good the deficiency and provide the child with the necessary apparatus.

DESPERATE CONDITIONS

In another instance the nurse found three old women who were living in a two room cabin with a young relative, a boy who was subnormal mentally. A niece and the niece's husband who had formerly lived with them had just been sent to the penitentiary for the murder of a neighbor. Of these three old sisters, one was apparently normal mentally, one was a low grade moron and one was imbecile. When the nurse found them, the imbecile was very ill, was in fact in coma. The normal sister, who was the directing head of the household and who seemed to be a person of fair intelligence, was so swollen with nephritis that she could hardly walk.

Since this condition had existed for a number of weeks, the house was in a frightful state of filth, the bedding had not been changed for many, many days and the condition of the patient was beyond description. The nurse, however, felt that this was "her job," as she expressed it, and that she had to see it through. She took from her bag her large cover-all apron, wrapped her hands with newspapers and went to work in that way to clean up. Finally, with the aid of the moron sister whom she directed about the cleaning of the house, and the boy who was living with them to help in the yard, she succeeded in reducing things to a state of some order in the house and the grounds about. She visited them each day until after a few days the patient died.

Meanwhile the nurse felt that something should be done for the nephritic sister. In the county seat was a private hospital run by physicians, although there was no arrangement for the care of charity patients. The nurse by her own personal efforts, visiting everybody she knew in the town, whom she felt was able to help, and presenting to them the case as she had seen it, was able to secure sufficient funds to send the nephritic sister to the hospital for two weeks. She had discovered meanwhile that there was a fourth sister who was married and living in a village a few miles away. She suggested—indeed urged—the remaining sister to go to her married sister's home, but the old woman was very obstinate and re-

fused to go. She said that she had had a letter from the niece in the penitentiary, asking her to be sure to look after Joe's clothes; that if she didn't Jim would sure get 'em, and she certainly wasn't going away and leave Joe's clothes for Jim. The next day the nurse received the news that the night following her departure with the sick sister, Jim, the young relative, *had* attempted to get Joe's clothes away from Lizzie. Lizzie had refused to let him have them and Jim had shot Lizzie.

Annie, the nephritic sister, improved under treatment and at the end of two weeks presented an almost normal appearance, but the funds were exhausted and there was nothing to do with Annie but to send her home, which the nurse did most reluctantly. On the diet of pork and hominy which was all that Annie was able to provide for herself, her condition soon returned to something approaching what it had been when the nurse first found her.

LACK OF COMMUNITY INTEREST

Another case which is at present disturbing this county nurse very much is that of a young mother who has three illegitimate children. She lives with her mother, who is also unmarried, in a one room shack far in the country. She has never been even to the county seat. The nurse first saw her a few days before Christmas when the last baby was born. She found this group almost destitute of clothes, not a pair of shoes among them, no food in the house and very little bed covering. In describing this girl the nurse says that the girl seems to be of good natural intelligence but utterly uneducated.

The nurse has tried to interest the community in this case but finds that it is difficult, if not impossible, to get their interest. She feels that if she could remove this girl from her present environment she might be able to develop her better qualities. She is devoted to the children and in spite of her poverty, has remained cleanly. This is a case where the lack of resources in the community makes it very difficult to handle this kind of a problem.

ITINERANT CONFERENCES

It is not easy to establish prenatal and child health centers and most of the nurses are compelled to rely on the itinerant clinics of the Bureau of Child Hygiene, but here and there the nurses have been able to secure the interest of a local physician and to establish a regular service. In this the midwives are very helpful, for they are learning the value of prenatal care and many of them bring in patients to the clinics and undertake to encourage the patients to follow instructions. Recently one of the nurses announced the establishment of a prenatal clinic in a county where one had never been held, and was overwhelmed by the attendance of forty-one cases. One midwife arrived with ten patients!

The fact that the nurse has been educating the people is also evidenced by the attendance at the itinerant conferences, which has gone as high as 70. These conferences, held in the county seat, from ten in the morning until five in the afternoon, are advertised through the home demonstration agent's clubs and through announcements in the schools. The parents are much more attentive to the advice of the doctor than they were a few years ago. They are less afraid of immunization than formerly and there has been a good response everywhere to the toxin-antitoxin campaigns.

Of course the great difficulty in bettering the condition of these children is again poverty, and although the doctors in the county and in the neighboring counties where there are hospitals have been very generous with their services, it is impossible to take care of the children who need physical correction without some cost—at least for the hospital service—and to many of these people the $12.50 or $15 which is necessary for the hospital care is absolutely impossible to find. Even the matter of milk is a difficulty for the cows are as scarce in these districts as the children are plentiful. It is easy to

advise the mothers as to the care and feeding of their children but when one knows that no matter what may be the willingness of the mother to carry out the instruction, it will be absolutely impossible for her to find the funds to do these things, the holding of clinics seems sometimes to be almost a farce.

USING COMMUNITY RESOURCES

In one county the nurse was originally employed by the Tuberculosis Association. She happened to be a person who had a very broad outlook and a peculiar understanding of people. She increased her work from purely tuberculosis work until she was putting on, with the assistance of the local physicians, a more or less general health program. In this county there was no health officer, there was no county hospital, but there was a county poor farm. The county was not so isolated as the one of which I was speaking, but it contained large numbers of small one-room cabins.

Every problem that occurred in the county seemed to be brought to this nurse for solution. She made use of all the church societies, and all the men's clubs to help her. She found in one instance an old negro man whose foot had been injured and neglected and finally became gangrenous. She consulted the doctor in the local private hospital in regard to the case and the doctor said that by amputating the foot and putting on a peg leg, the negro would be able to get along but that the cost of such an operation would be $50 including hospital care. The nurse went to the next meeting of the Rotarians in the county seat and told them the story of this negro man and said that she was sure the negroes in the community would be glad to help him if they knew of his need. She asked if the Rotarians would not be willing to send a representative to each negro church in the county to talk to the congregation on the following Sunday and tell them the story and ask for subscriptions toward the operation. The Rotarians agreed to do this and as a result the necessary funds were raised, the old man was operated upon, and is now cultivating his little piece of ground.

The American Legion and auxiliary provided a summer camp for undernourished children in one county, a large part of the food being contributed by the farmers, the county agent arranging for its collection.

The women's clubs and the home and farm demonstration agents, the Parent-Teacher Associations, and the American Legion are agencies that are of the greatest help to the rural nurse and if none of these organizations exist, and also if they do, the women's church societies are of great aid especially in the social service end of the work. In one county the nurse attended all meetings of the church and social organizations and was able to carry on an extensive social service program through them. As she found cases needing attention, she asked the societies in turn to be responsible for them, while she helped in the way of advice and supervision.

We think of crowding as a city problem yet any rural nurse can tell of hundreds of families who live in one-room shacks, father, mother, half a dozen children and often adult relatives. The city nurse may be able to evoke some sort of housing law to help combat such living, but there is nothing of the sort in rural districts. Often the very simplest sanitary arrangements are lacking not only in the homes, but in the schools as well. In one county the nurse found 75 per cent of the school houses without any kind of provision for physical needs. Under these conditions it is easy to understand why hook worm is prevalent, and typhoid fever continues to flourish. In one district where an intensive hook worm campaign had been put on a few years previously, over 60 per cent of the school children were infected.

In another county where there are fewer sources of help and where hook worm is rampant the health officer arranged to furnish free treatments for all school children infected. Where home conditions made it possible the medicine was sent to the parents to

give to the children. Where there was no mother in the home, or the parents were too ignorant to understand, the nurse arranged to have the children taken into the home of some club woman for the three days of the treatment.

A PRACTICAL SUGGESTION

In one county an effort is being made to use some of the abandoned one-room school houses, where schools have been consolidated, as health and community centers. The nurse, home demonstration agent, and farm agent are combining in this movement, and they hope by the end of the year to have several such centers in operation. They are to be used for clinics, classes, exhibits and demonstrations. In the county seat the nurse has a "Little Health House" which serves her as an office, as well as for classes and clinics. Perhaps the most active assistance comes from the Parent-Teacher Associations. In a number of communities the Parent-Teacher Associations have organized toxin-antitoxin clinics, the nurse only going in to help with the actual clinic. In the summer round-up they bring in the preschool children to the child health conferences. All this represents the finest kind of community coöperation.

PELLAGRA

Pellagra is one of the problems of the nurses working in the southern states, and is an especially serious one because it so often has mental illness along with its physical symptoms. It is easy to say that it can be prevented by proper diet but when so large a proportion of those who have it are totally ignorant as to what constitutes a proper diet and utterly unable to buy the necessary food, the nurse faces something that is discouraging. For years the home and farm demonstration agents and public health nurses have been trying to persuade the cotton and tobacco farmers that land, given over to raising a garden (beans, peas, spinach, etc.) brings in better returns than if planted in their favorite crop, yet even now good gardens are the exception in the country and in the mill villages almost unknown.

The nurses are using posters highly colored and simply worded to let people know what foods are most essential in preventing pellagra and setting forth the use of brewer's yeast in helping in its cure. These posters are put up in the little country and community stores and wherever possible in post offices. They are home made and are as gay as possible. Some are placed in schools and often the children make others to be used by the nurse elsewhere.

HEROIC STUFF

Much of this seems like a discouraging picture of the conditions which the rural public health nurse must face, and they really are so bad that I do not hesitate to say that I consider the rural public health nurse one of the most heroic figures of our time. Having been one myself, and being in the closest contact and most profound sympathy with scores of women, who are still carrying on this service, I know it has rewards which mitigate the hardships. No matter how difficult it is to awaken a desire for a better, healthier life in the majority, there are always eager receptive women who want what the nurse can give them and into whose lives she brings inspiration and color, and children for whom she can set a standard to work toward. Also there is a kind of friendship between the nurse and her people that is unique and satisfying—and there is the country itself, from which she may constantly renew her courage and cheerfulness.

Perhaps the hardest feature of it all is the lack of professional companionship and the intellectual stimulus that comes from it. We try to mitigate this isolation by quarterly meetings of all the nurses, by encouraging the nurses in adjacent counties to visit back and forth, by keeping a well stocked circulating library and by sending to them, as often as possible, an advisory nurse. We have not had a large turnover in our services, and think that we have been unusually successful in keeping the rural nurse rural.

Competitive Athletics for the Adolescent Girl

By Ethel Perrin
Staff Associate, Division of Health Education,
American Child Health Association

JOY and competition can go hand in hand when we play, but when games become a serious business, involving making and breaking of records and holding championships, joy disappears and grim determination takes its place. Opinions as to whether or not girls should compete in athletics, run the whole gamut between extreme conservatism and "the sky is the limit." Some contend that all so-called big muscle activities for girls should eliminate the combative qualities, and that all forms of self-expression should come through dancing, and activities such as diving. Others hold that girls need the highest type of athletic competition to make them fit for the strenuous life, and they urge a nearer and nearer approach to boys' athletic records.

As usual, a middle course seems wisest. Consider first some of the important outcomes which we may reasonably look for from an athletic program for girls of adolescent age.

To improve health
To teach coöperation and leadership
To provide skills for use in leisure time.

From "Play Day—The Spirit of Sport"
A Close-up on the Fun and Joy of a Play Day

No one can doubt that all three of these outcomes are of value, and it is easy to see how joyous play, out-of-doors, can contribute to a large degree.

IMPROVING HEALTH

In considering the first, it is not necessary to enter into a discussion of the physiology of exercise, for we know the necessity of muscle action in bodily development. We also know the physiology of fatigue and recovery and the dangers of over-fatigue. Can anyone who has ever seen the fatigue expressions on the faces of champion runners

crossing the line, wish to see the face of an adolescent girl wearing the same expression? Joy has the same relation to muscular effort that appetite has to digestion, and when effort brings a look of strain to a face, or appearance of fatigue to the body, the stimulus to health which we are after is lost. Here is a very definite sign to watch for, and an extreme evidence of the wrong thing is the hysterical manifestation by both winners and losers, after a championship game of basketball. Real spontaneous joyousness, as shown in our illustration, is not there. Too much is at stake to permit of fun. As one basketball candidate was told "you never will be a good player (note the word) until you stop having such a good time and get down to business."

DEVELOPING SOCIAL QUALITIES

In considering our second objective, the development of social qualities, two points stand out. As soon as the main emphasis is the training of an individual, or a team, to win over all comers, and to prove themselves (or their trainers) superior to every other person or team similarly trained, someone beside the participant must take the leadership. This means that the participants are more or less dummies so far as making decisions go, as they have been told beforehand just what to do in given situations in order to win, and there is no place, let us say, for indulgence in a sudden impulse of generosity to an opponent. If participation in highly competitive sports leads to good sportsmanship, coöperation, self-effacement to the advantage of the team and all the other long list of fine qualities we so often see set down, then professional baseball players should excel as good citizens, and our college athletes should be close seconds. It remains for someone to make a scientific study to prove this, and meanwhile there are evidences that too much of a carry-over has been claimed.

The second point that comes from observation is that pitting two champion teams against each other does not lead to a better understanding. One of the reasons offered for inter-group competition is an opportunity for better acquaintance with your neighbors as an antidote for provincial satisfaction with your "home town." However, when you are playing against an unknown neighbor, divided by the layout of the game, there is very little opportunity to "chum" with your opponent. Nor do glory from winning, nor chagrin from losing, tend to foster a spirit of comradeship, particularly when your home community takes the whole thing very seriously, and expects the players to help the city fathers "put the town on the map."

SKILLS FOR LEISURE TIME

In consideration of the third outcome, it is easy to see that most of the highly competitive type of athletics do not take into consideration what use the adolescent girl can make of the activities after she has left the school or college, or church, or community center or factory team.

Now for the cheerful, positive side of the situation. We do believe that athletics and games can promote all three of our stated outcomes to a great extent and to the happiness of all concerned. What we need is more use of competitive games for girls, and in such a way that all will be included rather than the privileged few, and that social relationships shall be improved rather than injured. This can be done through attention to three fundamental principles:

Consideration of individual needs, both physical and preferential
Consideration of community recreational opportunities
Mingling rather than separation of groups coming together to play in games.

The first principle requires a health examination with an intelligent use of the findings, and consideration of what each girl prefers to play.

The second, some thought as to whether the girls will ever have a chance to play the games they learn under leadership, when they are "on their own."

A NEW IDEA

The third is a really new idea in the world of sportsmanship and one that is

being experimented with for girls all over the country. The scheme sounds so simple that it is difficult to grasp its full significance. When two or more groups come together to play basketball or volleyball, or to jump or run or swim, every team is made up of a mixture of participants from all groups. Then they are really playing with each other rather than against, and there is at least a chance of friendliness and a better understanding as a result. All girls should have the opportunity of playing frequently with new teammates, for this is after all, a real life situation, and offers experiences which can be made use of all along the way.

A group of people calling themselves the Women's Division of the National Amateur Athletic Federation was organized under the leadership of Mrs. Herbert Hoover in 1923. The Federation has a membership of over eight hundred groups and individuals. The list includes women's colleges, schools, industrial organizations and such organizations as the Playground and Recreation Association of America, the American Child Health Association, the National Council of Catholic Women, the National Council of Jewish Women and the Girl Scouts, Inc.

Three outstanding aims of the Women's Division are:

Through federation of all these agencies, to obtain a point of view which is broad, far-reaching and representative.

To set up standards and programs in girls' athletics that are both sound in principle and effective in operation.

By a national organization network of states and cities, to put these standards before the people.

The headquarters are at 370 Seventh Avenue, New York City.

With the Olympic Games, the peak of intense competitive athletics, coming to Los Angeles in 1932, and with women having entered as competitors, there is need of serious thought and concerted action by the people who have at heart the health and happiness of the adolescent girl.

Women Playing Ball—Ancient Egyptian Wall-Painting (circa 2800–2500 B.C.)
Reproduced from The Illustrated London News

ADDITIONAL SUMMER COURSES

(See previous list in April magazine)

University of California, Los Angeles, Cal. July 1 to August 10.
Courses in Health Education, Nursing Aspects of School Hygiene, Principles and Practice of Public Health Nursing. Write to Dean of Summer Session in Los Angeles, Room 710, 815 South Hill Street, Los Angeles.

New York University, New York City. Registration July 1.
Department of Physical Education and Health, Summer Camp of the School of Education. Courses in Principles of Teaching Health, Methods of Teaching Health, etc. For further information write Director of Summer School, New York University, Washington Square East, New York City.

Cornell University, Ithaca, N. Y.
Summer courses in Health Education, Hygiene of School Child, etc. For further information write Secretary, Summer Session, Cornell University, Ithaca, New York.

New York State Teachers College, Buffalo, N. Y. July 1 to August 9.
Teacher Training Course for graduate nurses. For further information write Mrs. I. W. Baker, Director, Home Hygiene Service, American Red Cross, Washington, D. C.

Pennsylvania State College, State College, Pa. July 2–August 10.
Courses in Principles of Public School Nursing, Methods in Health Education. For further information write to Director, Summer Session.

Steps in Planning a Health Education and Publicity Program

AUDIENCES — HOW TO SELECT AND CLASSIFY THEM

By Marjorie Delavan

Michigan Department of Health, Lansing, Michigan

Paper from a symposium of the Public Health Education Section, American Public Health Association, at the Annual Meeting, Chicago, October, 1928, published simultaneously in the *American Journal of Public Health*. The other papers from this symposium will be published in the *Journal* in May and June.

JUST as the objectives of a health education and publicity program are determined by a thoughtful and unprejudiced analysis of existing conditions, so are the audiences to be approached defined by the objectives. The term "audiences" in this sense includes everyone who can be reached by any of the publicity avenues at our command.

Audiences are always, in one way or another, selected. They are naturally and automatically selected by the objective chosen. They may then be further and more arbitrarily limited on the basis of available finances, personnel, or time. Our newspaper stories, posters and exhibits carry on their own selective processes by the material that they present. Since this is inevitable, we can agree that selection may well be made conscious and reasoned in view of its importance to the campaign.

THE PRIMARY AUDIENCE

The first step in choosing our audiences is to decide *what individuals and groups are directly and indirectly concerned in the attainment of our objective.* To discuss for a moment the question of "individuals" versus "groups"—we have become so thoroughly organized that we think in terms of groups. The organized group is tangible, it has a president who can be convinced, a well defined and counted membership, and a regular meeting day. In some types of campaigns, such as teaching personal hygiene to school children, dependence on the organized group is a safe solution. When time and funds are limited it is often the only one, but with adult groups, where belonging is a matter of choice, it is usually incomplete because the very person we wish most to reach may not be enrolled. Valuable and temptingly convenient as it is, it can never take the place of the individual approach whenever the latter is feasible. Covering the organized groups of a community is not equivalent to reaching the whole audience. In any publicity campaign it is well to burn a little midnight oil over the problem of the person who does not belong to clubs.

Going back to the mechanics of the selective process, the audience of primary importance is made up of those individuals upon whose direct action rests the attainment of the objective. In a diphtheria protection program it is the father and mother of the diphtheria-age child. In periodic health examination campaigns it is the adult who comes within the age group threatened by the degenerative diseases. In a vaccination campaign it is the unvaccinated—or un-revaccinated—person. In a bond issue for a safe municipal water supply the voter who drinks the water is the individual most intimately and directly concerned, the one whose action we wish to stimulate.

GROUP AFFILIATIONS

Having chosen the individuals who make up this primary audience in any campaign, the next step is to *map out their convenient group affiliations.* In what organized groups can we find them? Does the prospective mother belong to clubs? Are the fathers and mothers of diphtheria-age children members of any groups? If we can honestly answer "yes" then the solution is enormously simplified. Unfortunately, we often have to answer "no," especially when it comes to pros-

pective mothers and mothers of preschool children. Here individual approach may be the only inclusive one.

The individual approach means direct contact with the individuals making up the primary audience, with no reliance upon intermediate agencies. For instance, in the campaigns for the promotion of breast feeding that are being carried on by the Bureau of Child Hygiene and Public Health Nursing of the Michigan Department of Health, the path to the mother is direct. The nurse gets from the county clerk the names of parents of babies under six months, or under one year, if a more thorough canvass can be made. She then visits those mothers. In this case the message is delivered directly to the primary audience, and to every member of it. A variation of this method can be illustrated by the preparation for preschool clinics. A plan of carefully districted home calls can be delegated to a group, such as a mothers' club. This is simply the utilization of a group in the individual approach.

Having selected our primary audience and mapped out its group affiliations, the next step is *to determine the agencies, individuals or groups that are not personally concerned in the objective but are necessary to the setting of the stage.* For after all, most of our health campaigns need stage setting. There is no object in creating a desire for action unless there is a reasonably easy outlet. And to limit our selection of audiences to those that are provided with that outlet is hopelessly to limit our campaign. There is no point in urging parents to take their children to a physician for toxin-antitoxin in a school where half of the parents cannot afford the treatments, or in a community where there is only one elderly physician—and he does not take any stock in new-fangled notions. No particular gain is made by urging regular medical care during pregnancy when our prospective mothers live in the plains country far from a doctor. When we select our audiences we must choose those that have the facilities for action or provide such facilities.

THE SUBSIDIARY AUDIENCE

The groups and individuals that we appeal to in this matter of providing the necessary background for action we can term our subsidiary audience. In diphtheria prevention campaigns we enlist the physicians, so that the technical side may be cared for. If the campaign is to be a community venture, with the treatments free to all children, we appeal to the groups that direct or at least influence the expenditure of public funds. We ask the support of the school authorities so that our clinics may be held in the school house and announced through school channels.

These assisting audiences may or may not include the members of our primary audience. They are chosen on the basis of community leadership rather than immediate contact with the objective. In terming them subsidiary audiences and mentioning them last, I do not in the least minimize their value. They are often the first audience to be approached, and the deciding factor in the whole campaign.

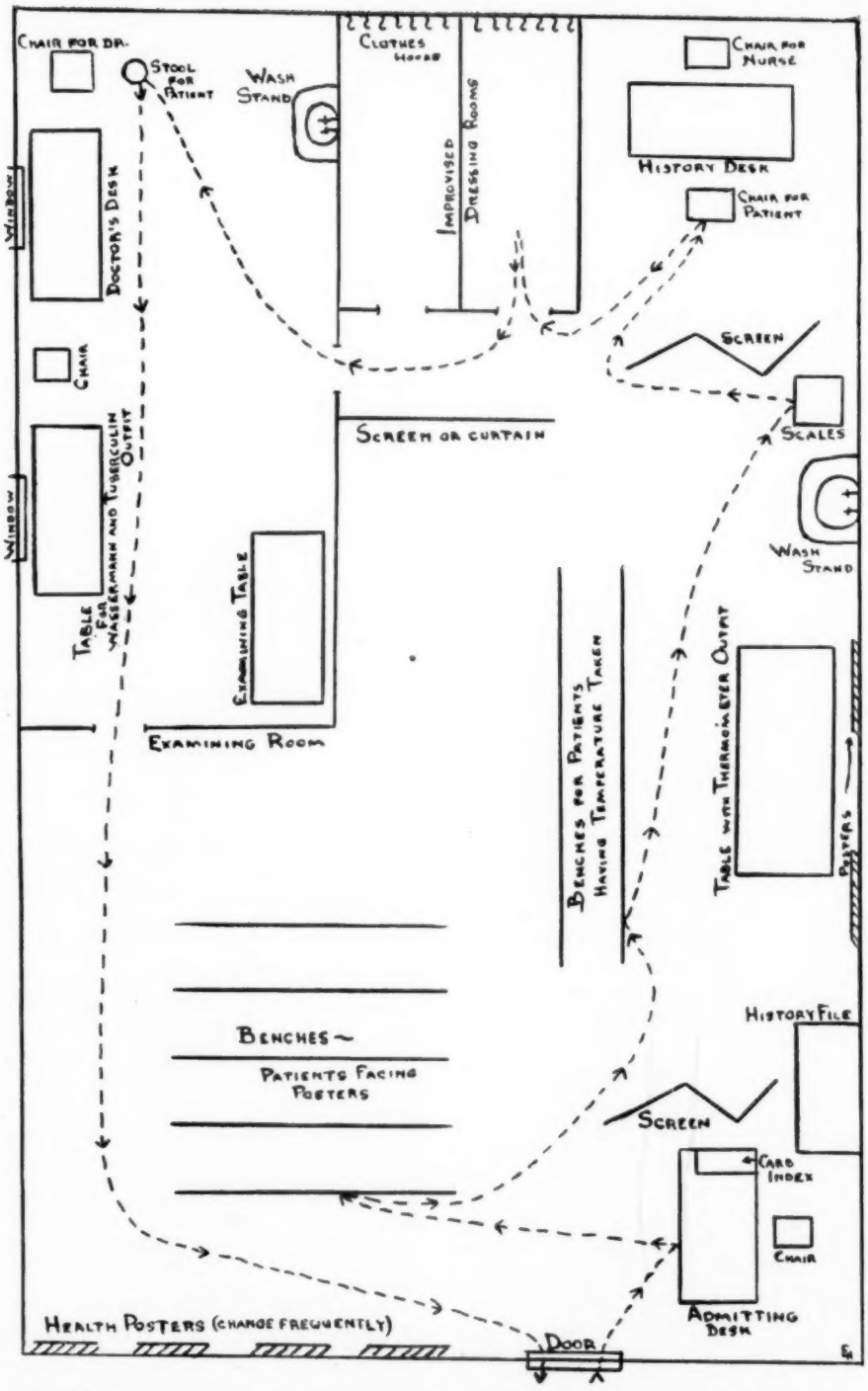
When we have selected our primary audience, found out its affiliations, and chosen our assisting agencies, we have a reasonably clear picture of our composite audience. We are struck at once by the overlapping. Groups are not neat pigeonholes for people, in which people may be expected to stay. With our present maze of organizations there is bound to be overlapping, and it is wasteful only when it is duplication. If our material is carefully sifted and prepared, it will reinforce itself by being presented from different angles. Overlapping is not necessarily a drawback in the choosing of audiences.

To summarize: The audiences in any publicity campaign are defined automatically by the objectives of the campaign, and limited arbitrarily by the director.

The primary audience is made up of the individuals directly involved, considered as individuals or as groups.

The subsidiary audience consists of the assisting individuals and groups, chosen on the basis of civic leadership.

A thoughtful selection of our audiences, and limitation in the interest of thoroughness and permanence aids tremendously in the success of the campaign.



Suggested Set-up for a Tuberculosis Clinic with Limited Space—A Minimum of Two Rooms Is Required.

Tuberculosis Nursing for Public Health Nurses*

By Violet H. Hodgson, R.N.

THE PUBLIC HEALTH NURSE AND CLINIC SERVICE

IT IS well to remember that any lasting benefit which may be conferred upon the tuberculosis patient under the present method of treatment of the disease, will be the result of a process of education. The clinic is a most important and a strategic place for coördinating the teaching of the physician and the nurse in such a way that the lessons taught will be of lasting value to the patient.

Efficient management of a clinic necessitates the observance of a certain number of routine procedures, the most outstanding of which follow.

GENERAL MANAGEMENT

The clinic should be set up and ready to function *promptly* at the time when patients have been told to arrive. A definite time should be stated for clinic hours. Exceptions to the policy of not admitting patients after closing hour may be made in special instances when the patient gives a very good reason for being late, provided the exception has not been made several times for the same patient.

Each nurse should know and understand the specific duties required of her before the clinic starts. Courtesy, friendliness, sympathy, dignity, poise and a sense of humor, are indispensable in gaining the confidence of the patient.

The nurse should see that the patient clearly understands the physician's instructions before leaving the clinic.

Patients should be seen by the physician in the order in which they arrive at the clinic. In a free clinic, it is not possible to allow patients to choose their physician.

Paper bags may be used as receptacles for soiled paper napkins, tongue depressors and waste pledgets of cotton. They may be suspended from small hooks at convenient places.

Assure the patient of privacy in undressing and dressing. It is desirable to have only one patient at a time undressed and waiting for examination. A nurse should remain in the examining room when female patients are being examined.

Thoroughness in all procedures is essential, regardless of the number of patients attending the clinic. The patient is interested primarily in the kind of treatment which he receives and not in a large clinic attendance.

If there are several nurses on duty at the clinic, those admitting patients and taking temperatures may leave for the field at the close of the admitting hour or after the temperatures have been taken. This helps to reduce the cost of the clinic service.

If the clinic service is confined to tuberculosis, the nurse may be guided in her new admissions by admitting only those cases giving a history of symptoms suspicious of tuberculosis or having been in close contact with the disease. It is well to determine a territorial boundary line for the area which the clinic is prepared to serve.

Blood for Wassermann test should be taken by the physician. Tuberculin test should be given by the physician.

ROUTING PATIENT THROUGH CLINIC

The efficiency of the nurse in charge of the clinic is reflected in a large measure in the smooth running of the clinic. The following suggestions are made with this objective in mind:

On admission to the clinic give patient a slip with his name and a number indicating the order of his arrival and the order in which he should be examined.

* Continuation of the article begun in the April number of The Public Health Nurse.

Take temperature, pulse, height and weight and record on patient's history. The time of weighing is ideal for discussing rest, diet and exercise and their favorable or unfavorable effect on the patient's weight.

History—With a new patient, the nurse may obtain the sociological data, history of exposure, and subjective symptoms. A satisfactory contact with the patient at this time will determine in no small measure his willingness to return to the clinic.

If the patient has previously attended the clinic, obtain a history of events related to his physical condition since the last visit to the clinic. The following are examples:

Ability to work—full or part time.
Expectoration—amount, time of day, blood streaked.
Hemorrhage—amount, color.
Illnesses.
Present symptoms most annoying to patient.
Appetite, sleep, exercise.
Social problems in the family.

Perhaps the simplest method of giving a picture of the patient's condition (subjective) is to record only positive symptoms and conditions which have a bearing on the physical condition, and state that history is otherwise negative. This calls for a broad knowledge of the most important factors related to tuberculosis and the ability to apply this knowledge in eliciting a complete history from the patient.

Prepare patient for examination.

Examination by physician. This is the service for which the patient has come to the clinic. It is the ideal time for the physician to carefully instruct the patient in the cure and prevention of the disease. Plenty of time should be allowed the patient to ask questions and receive satisfactory answers from the physician.

Be sure patient understands instructions given before leaving clinic. Give return date.

Thermometer Tray

Thermometers: mouth and rectal in alcohol solution, containers plainly marked "mouth" and "rectal."
Green soap solution.
Pledgets of cotton in container.
Tube of vaseline.
Paper bag for waste cotton.

Wassermann Tray

Luer glass syringe
Needles
Rubber tubing (tourniquet)
Sterilizing basin
Alcohol
Pledgets of cotton in container
Adhesive
Paper bag for waste cotton

Tuberculin Test Tray (Von Pirquet or Intradermal)

Scarifier
Syringe
Needles
Tuberculin
Sterilizing basin
Alcohol
Pledgets of cotton in container
Adhesive
Paper bag for waste cotton

Equipment for Physician's Desk

Ink (red and black)
Pens
Pencil
Squares of tissue paper in container
Tongue depressors in container
Paper bag for used tissue paper
Flashlight
Record forms
Prescription blanks
Literature for patients
Specimen bottles
Sputum
Urine

SPECIAL TECHNIQUES

HEIGHT AND WEIGHT

Weigh patient without sweater, overcoat and overshoes. If there is a gain in weight, make favorable comment. Have the patient supply a reason for gain. If there is a loss in weight, make no unfavorable comment. Discuss with the patient the possible reasons for the loss.

In the case of a child, if markedly underweight and with other symptoms of malnutrition, make a special note on the record. This will indicate to the nurse the need for special attention to remedy any situation in the home which may be responsible for this condition. Diseased tonsils, inadequate or improper diet, bad eating habits, nagging parents, lack of proper amount of rest, poor ventilation, may be causative factors.

TAKING THE HISTORY

Insure privacy to the patient. Ask questions in a friendly and interested manner. Observe patients' reaction to certain questions. He may not clearly understand, or may object to giving the correct answer. The history should be a clear and consecutive picture of the patient's condition since the onset of the disease.

Be sure statements are relative to

the question. For example, under item, "Reason for coming to clinic," do not use such statements as "examination" or "advised by nurse." These may, indeed, be the patient's reason for coming but the nurse in getting the history should search further for the underlying causes, such as are expressed in the terms:

"Loss of weight and blood-spitting,"
"Exposure to tuberculosis,"
"Referred by family physician."

Research is sometimes necessary in obtaining a satisfactory history of exposure to tuberculosis. If the nurse senses a hesitancy on the part of the patient in using the term tuberculosis, she may obtain the information more readily by using such terms as "lung condition" or describing the symptoms of tuberculosis which some member in the family may have had and who died of "pneumonia."

Young adults sometimes report parents "living and well." A chronic fibrotic type of tuberculosis may remain in an apparently stationary condition over a period of years, and, because of this, the parent may seem normal to the child.

Inquire about the health of relatives if no history of exposure is obtained in the immediate family. Children sometimes live with a tuberculous relative long enough to become infected and acquire the disease. Boarders may be a source of infection. Source of the milk supply at present, and occasionally the past sources, are of interest in glandular tuberculosis.

CLINIC REPORT TO FIELD NURSE

The following may be included in the clinic report to field nurse:

Diagnosis, temperature, weight, noting gain or loss, orders, physician's findings that may be of value in her teaching in the home; *e.g.*, evidence of activity of lesion, ability to work, amount of rest, special diet, date of return to clinic.

LABORATORY REPORTS

Reports on examination of sputum, blood, urine, etc., should be copied on the clinic record as soon as received.

LAMP TREATMENT

Treatments are given only upon the written recommendation of the physician. The order should specify the part of the body to be exposed, time of exposure, and the distance between lamp and body. Patient and nurse wear dark glasses.

RECORDS

Clinic records provide valuable material for the epidemiological study of tuberculosis. They should be accurate, complete and systematized to meet the needs of all groups interested in the control of tuberculosis. The following are the essentials in a simple record system:

A central card index file containing a separate card for each patient. Cards and clinical records are filed alphabetically. The card may have space for patient's clinic number, name, present and previous address, date of birth, name of father and mother, nationality, date of admission, date of and reason for discharge, diagnosis. Keep active and discharged cases separate. Keep record of patients in sanatorium in a separate place in file. Return to active file when patient leaves sanatorium and comes to clinic.

A daily summary should be kept; this may include

No. of patients at clinic
No. of new patients at clinic
No. of old patients at clinic

Under "new patients" list:
No. with diagnosis of far-advanced and pulmonary tuberculosis
No. with diagnosis of moderately advanced pulmonary tuberculosis
No. with diagnosis of minimal pulmonary tuberculosis
No. with diagnosis of hilum tuberculosis
No. with diagnosis of tuberculous cervical adenitis
No. with diagnosis of bone tuberculosis
No. with diagnosis of other types of tuberculosis (specify)
No. with diagnosis other than tuberculosis (specify)
No. of contacts
Age—under 1 year
1 to 6 years
6 to 14 years
No. of hours spent in clinic by nurse
No. of hours spent in clinic by doctor

REPORT ON NURSE'S RECORD

The report of the clinic findings and recommendations may be noted on the nurse's record in red ink. When the clinic serves the patients supervised by a number of nurses in the field, a report should be sent to the supervisor, or to each nurse when there is no supervisor. This gives the nurse an estimate of the effectiveness of her teaching and indicates special points in the patient's daily régime which need emphasis.

REPORT FROM HOSPITALS AND CLINICS

A written request should be made for reports on patient's condition while under care in a hospital or clinic. This report should be filed with patient's clinical record.

SANATORIUM APPLICATION

Application for sanatorium care should be filled out by the clinic physician. When the patient is unable to assume financial responsibility for such care, the nurse should assist in making the arrangement.

SANATORIUM CARE

The length of time a patient remains in the sanatorium depends in no small measure upon the kind of instruction he has received from the nurse previous to admission. All her efforts in getting the patient examined and securing his consent to accept sanatorium treatment may be completely frustrated if he does not understand what will be expected of him, and if provision is not made for the care of his family or dependents.

INFORMATION ABOUT SANATORIA

The nurse should know:

Names and location of all state, local and private sanatoria to which patients in the nurse's district are eligible for admission; requirements for admission (residence, financial status, color, age, sex, nature of disease); admitting days and hours; visiting hours; clothing required (to avoid appearance of almsgiving, nursing organization should turn over clothing supplies to be issued through the relief agency); approximate cost of transportation; how to apply for admission.

GENERAL ADVICE TO PATIENT AND FAMILY

The sanatorium is a "school" where the patient may learn how to get well. Sanatorium rules are made for the benefit of the patients. These rules will oblige him to do many things that he was not accustomed to doing at home It would be impossible in many instances to adopt such a régime in the home, for both places are built and used for entirely different purposes. With the right mental attitude, viz., a determination to get well, it is no hardship to carry out the treatment prescribed, for he will find that all the other patients are doing the same thing.

Rest gives the diseased tissue a chance to heal and the body an opportunity to build up a resistance to the infection. Therefore he will find that provision is made to have it in abundance. To provide ideal conditions for resting, visitors are allowed on certain days only, and visiting hours are limited to a definite period.

The food may be different from that to which he is accustomed at home. Assure him that the menu of the sanatorium provides the food elements essential to body growth and repair. It is most important that he learn which foods are good for him, so that he may continue this part of the "cure" when he returns home.

The amount of exercise which he will be allowed will be determined by his physician. While at home, many patients consider walking the least strenuous exercise. A new interpretation may be given by explaining that "sitting up in bed" is exercise in the treatment of tuberculosis.

Entertainment will be provided to meet the patients' needs. The family should coöperate with the patient in making the adjustment to his new environment.

REQUEST FOR HOSPITAL OR CLINIC REPORT

Date.....

To .....
(Name of Institution)

Kindly send us a report of the physical findings, diagnosis and recommendations on

....
(Name) (Address)

who has been under care at your institution.

He (she) is under supervision at the Doe Tuberculosis Clinic at the present time.

Signed.....
(Nurse in charge of clinic)

(Return report to be torn off on perforated line)

....

Date.....

To.....
(Physician in charge of clinic)

.....
(Address)

The following is a report on

....
(Name) (Address)

(Space for report)

Signed.....

.....
(Name of Institution)

REPORT TO SOCIAL AGENCY *

From.....
(Name of nursing organization)

Date.....

To.....
(Name of social agency)

.....
(Name of head of family)

.....
(Address)

	Family	Date of birth	Occupation	Health (diagnosis, nutrition, etc.)	Income reported by family
M	Joseph	1887	Barber	Wife reports "not very strong"	.....
W c	Mary	1890	Housewife and laundress	Underweight, otherwise physical examination negative	$4 week
c	Anna	1910	Corset factory	Minimal pulmonary tuberculosis. Sanatorium recommended	18 week
c	John.....	1919	School	Positive Von Pirquet. Underweight	.....
c	Alice.....	1923	School	Positive Von Pirquet. Underweight Diseased tonsils	.....
c	James.....	1926	Home	Tuberculosis of Tracheo-Bronchial glands	.....

Reasons for referring:

Husband deserted family 3 years ago, whereabouts unknown. Has not contributed to support of family since that time. Anna will not consider sanatorium care until financial arrangements are made to take care of the family. Budget analysis shows family needs $31.00 a week to provide adequately for their health needs. John is tall for his age and because of this has been accepted into a gang of older boys whose influence is harmful. Stays out late at night.

Signed.....
(Nurse)

.....

Date.....

Report on..... .....
(Name of family) (Address)

(Space for Report)

Signed.....(Visitor)

.....(Agency)

* See page 207, April magazine.

PROVISION FOR THE FAMILY

If the patient is the bread earner (father or mother) in the family, provision must be made for the care of the dependent members until the patient is able to return to work. The problem should be turned over to a social agency. In communities where there is no private family welfare agency, application should be made to the local offcial welfare agency, relatives, church, local Red Cross, etc.

THE EX-SANATORIUM CASE

The sanatorium has taught the patient the essential factors in the treatment of tuberculosis in the sanatorium. The nurse should show him how to adapt this teaching to the home. To do this, it is essential to visit the patient *as soon as possible after discharge* from the sanatorium—at least within a week. A delay in visiting may mean an adaptation by the patient to the home environment rather than an adjustment of home conditions to meet his needs. Such a change calls for education of the entire family. A written outline of the daily régime is helpful in many instances.

REPORT TO SANATORIUM ON DISCHARGED CASES

When the local public health nurse is requested to report regularly to the sanatorium on discharged cases, a mimeographed or printed form can be used to advantage. Unless otherwise stipulated by the superintendent of the sanatorium, the following items should be included on such a form:

Name
Present address
Old address (if patient has moved since leaving sanatorium)
Occupation—part or full time
Weight Afternoon temperature
Symptoms (hemorrhage, sputum, night sweats, loss of appetite, etc.)
Date of last examination
Report of last examination
Remarks
Signature

OCCUPATION FOR THE TUBERCULOUS PATIENT

The following factors should be considered in advising the tuberculous patient regarding occupation:

Is the work room dark, damp or poorly ventilated? Does it necessitate heavy lifting? Is there a possibility of excessive fatigue? Are the hours long? Is there a dust hazard? Stone and metal dusts should be avoided wherever possible. Does it involve handling of food? Does it mean caring for small children? His old job requires less adjustment than a new one and should be recommended if it meets the requirements of the patient's condition. Advise against an outdoor job that requires heavy lifting or exposures to all kinds of weather.

The patient with pulmonary tuberculosis should be advised to consult his physician before engaging in any occupation.

REFERENCE READING FOR THE TUBERCULOSIS NURSE

An understanding of the nature of tuberculous disease, a knowledge of the terminology peculiar to it and the accepted methods of treatment are essential in the equipment of any public health nurse. The following are suggested for this purpose:

Books

Rules for Recovery from Tuberculosis, Lawrason Brown, M.D.

Tuberculosis, a Primer and Philosophy, M. MacLean, M.D. (Very practical treatises to suggest to patients.)

Tuberculosis, its Cause, Cure and Prevention, Edward O. Otis, M.D.

Tuberculosis and the Community, John B. Hawes, M.D.

The Care of Tuberculosis, J. A. Meyers, M.D.

Pamphlets

What You Should Know About Tuberculosis, National Tuberculosis Association.

Sleeping and Sitting in the Open Air, National Tuberculosis Association.

Hints and Helps for Tuberculosis Patients, Dr. Chas. L. Minor. (Helpful pamphlets in reinforcing the teaching in the home.)

Diagnostic Standards, National Tuberculosis Association. (A clear statement of the terminology in Tuberculosis, diagnostic measures, treatment, etc.)

A Nurse Looks at the Future

We have the privilege of printing in advance Chapter VII of Mary Beard's book, "The Nurse in Public Health," which will be published in the immediate future by Harper & Brothers. This concluding chapter gives Miss Beard's vision of "The Future."

IF IN 1919 we had set down our ideas of the probable status of public health organization in 1929 it is not likely that we could have given an adequate picture of the great developments of these past ten years. To look ahead is a fascinating occupation; to look ahead into the future of the community health program in this country involves so many administrative organizations and so many types of professional work that prophecy becomes peculiarly adventuresome. However, as I come to the end of this book, it seems evident that the foregoing chapters will be clearer and more interesting if they are considered in the light of such an imaginative future.

The nurse in public health (Chapter I) has become essential to teach health in homes, at clinics, in schools, and in industrial establishments. Since rural conditions make it difficult to provide proper facilities for health (Chapter II), the public health nurse is more needed in remote country places than elsewhere; but it is difficult to supply enough public health nurses for rural communities, first, because money for every purpose is scarce in the country and, second, because conditions of living and of working isolate rural nurses. In the United States there has been rapid expansion of public health nursing in cities and, particularly in the Eastern states, a tendency for privately administered public health nursing associations, such as visiting nurse societies and child welfare associations, to carry on work of the type for which in the Western states public health officers incline to assume responsibility. We are giving a good deal of thought (Chapter III) to the allocation of administrative responsibility for public health nursing work. Economy and efficiency urgently demand that we do so. To study the beginnings of a movement (Chapter IV) sometimes helps to make present and future clearer; and nursing as a profession is only just beginning to be introduced in some European countries. It is significant of the trend of our times that it is the public health program and the need for public health nurses which is stimulating the founding of schools of nursing in these countries.

Foremost, perhaps, in our thoughts as we plan for the future is the excessively high maternal mortality rate of the United States today (Chapter V). Public health nurses are deeply involved in our present community programs for maternal care. A study of their functions in this program in England offers helpful suggestions for an extension of our present program.

One cannot consider the nurse in public health as an isolated worker apart from other nurses engaged in other forms of nursing (Chapter VI). At this moment fundamental changes in nurse education occupy the attention of those most concerned in community health programs, for there are not enough well-qualified public health nurses to make permanent those public health activities the value of which has been demonstrated. Furthermore, it has been shown that present methods of educating public health nurses are wasteful and inadequate. As these methods are improved upon we may expect to see (1) the elimination of unqualified nurses, and (2) fundamental changes in living and working conditions in the field of graduate nurse practice.

From the School of Nursing at Yale a class of thirty-four young women will graduate in 1931. Into what conditions of work will then enter? What will the ten years following 1931 bring about? Like other young women intelligently prepared for a profession,

they will expect to find opportunities to practice which will give them professional leadership, opportunities for promotion, reasonable hours and living conditions, and an assurance that the work they will do is needed in the community.

Stabilizing Directories

Just as public health nursing has gone through a period of standardization in the past seventeen years so, there seems reason to believe, will the other branches of nurse practice be organized to permit of such standardization as will produce a stability in private nursing, in floor duty, and in graduate executive positions in hospitals, so obviously lacking today. There are already seventy-nine reorganized nurses' directories in the United States. This new type of directory has been called a "coöperating nurses' center." So far little more has been accomplished in these centers than to recognize that coöperation is necessary to the success of any effort to change private nursing practice so that it will conform to other professional fields of work. . . . .

Coöperation within the directory would mean a distribution of calls to cover holidays and Sundays, night duty, and emergencies, so that much of the present dissatisfaction and apparent shortage of nurses would disappear. Only one out of three nurses belongs to the American Nurses' Association, only one-ninth of the total number of nurses in the United States take the official nursing journal. Our alumnæ associations are little influenced by our local leagues of nursing education, for the reason that we are divided into three national associations—the National Organization for Public Health Nursing, the National League of Nursing Education, and the American Nurses' Association—and the struggle to be faithful to the demands of each one of these separate organizations becomes overwhelmingly complex and leaves no energy for concentration upon the common needs of all three groups of nurses.

One magazine, one professional national organization with sections representing special interests, a concerted effort to enroll the other two out of the three nurses now members of a national association! When these aims have been achieved—and they will be achieved—we may look for better and more stable conditions in the profession of nursing.

Into such a future one's imagination makes adventurous flights. Nursing education will repeat the story of medical education: many of the nursing schools will disappear and with them many of the undergraduates of poor educational background. There will be less distinction between the three fields of nursing; for with the growth of hourly nursing, the visiting public health nurse and the private hourly nurse will come into a field so similar as to be indistinguishable. Furthermore, if "group" nursing in hospitals proves practical the highly individualistic private duty nurse will emerge to become again more completely a part of the nursing service provided by the hospital for all patients. . . . . More graduate nurses in public wards, and changes in hours, salaries, and living conditions for this group, will perhaps be a part of this future organization and will have a tendency to bring back a certain atmosphere now lost in our hospital ensemble—an atmosphere which comes through better integration of nursing services.

In City Homes and Rural Communities

And in the city homes from which hospital patients come and to which they return there will perhaps be other changes resulting from greater intelligence with regard to health and from better practical knowledge of the principles of home nursing. The fact that high schools have so generally introduced home nursing courses and that public health nurses are so much more generally accepted in the community will result in many common nursing procedures being carried on by the family. Already "health centers" have become to some extent and in some communi-

ties a source of direction for such home nursing care. In families where incomes are large the establishment sometimes maintained by a consultant in medical practice takes to some extent, even today, the place of such direction. A dietitian is a member of such a consultation plant; specialists in several branches of medical practice may also be a part of it. Why not a visiting nurse to act as liaison officer between home and consultation room?

And in the rural communities small hospitals might, with the growth of health center activities, introduce similar programs involving visiting nurses who would undertake the direction of home nursing, correction of physical defects, and prevention of illness. Why could not a central nursing school for a whole state direct all the clinical nursing service in the small hospitals in rural communities necessary to the health of the people living there? Perhaps the future will show us how this will come about.

We do not know how the cost of medical care is to be defrayed in the future; but the bill for health is unpaid today; and the fact that it is unpaid, that we cannot put into effect those means now known to produce health, has stirred us to study and investigate, so that we may perhaps be more ready to answer this question in ten years' time than we are now.*

Changing Perspectives

Today doctors and nurses are concerned with changing the perspective of schools of medicine and nursing so that the idea of health and the prevention of disease will become the basis of all work with patients and their families instead of representing an additional group of facts superimposed upon a fixed body of information dominated by pictures of pathological conditions of one kind or another. The natural sciences will come closer to the social sciences, and thinking health and teaching the principles of health will come to be the first preoccupation of doctor and nurse. Already leaders in the field of mental health have shown the way to this goal. It is not a desirable thing to live more days if they are not to be better days; but it seems possible to predict that the lengthening life span will carry with it so much more vigor to the individual that length of days will be worth working for.

Already we know that many more public health nurses are needed to carry through to completion our known-to-be-effective plans for saving life and making it possible for the lives thus "saved" to "see good days." We know that these nurses must be more in number and better in quality. The rural community needs more attention. The beginning of the cycle of life—maternal care—has been terribly neglected. Not only is there appalling loss of life in childbirth in the United States, but the ill-health resulting from poor care in pregnancy and at confinement is no less shocking because there is little statistical evidence to show how extensive it is. A study of the further uses of public health nurses may bring about changes in procedure which in the years to come will more nearly approach Denmark's methods, or those now carried on in the rural mountainous regions of Kentucky.

And if we permit ourselves to imagine these things, we must also see the general public becoming better and better informed and taking an active part in all community health work. As members of community health committees laymen and laywomen will surely be more and more active in securing health legislation and the appropriation of public funds for health work, in extending health organization, and in developing plans for the education of the community in matters concerning health. For the keynote to all health activity is education, and this the public is learning to demand.

* Committee to Study the Cost of Medical Care.

BAGS

For public health nurses who do not need bedside nursing equipment

Bureau of Educational Nursing,
Association for Improving the Condition of the Poor, New York, N. Y.

AS the name Bureau of Educational Nursing implies, the staff nurses of the "A.I.C.P." are responsible for continuous education in health values of the families under their care. In many instances their long period of service makes possible a plan for complete reëducation of the entire family. The effort is made to help every individual in every family to appreciate how much mental and physical health mean in successful living. Perhaps one of the most important things the nurses are striving to do is to help underprivileged parents understand the needs of their children as they grow up in an environment which is all too often handicapping, both mentally and physically. The outline of routine health service for A.I.C.P. families includes the following:

Annual health examination for all members of the family.

Use of available clinics and agencies to secure correction of all defects possible; and to secure special care as necessary for cripples, cardiacs, malnutrition cases, suspected cases of venereal disease, etc.

Interpretation to the clinic workers of the family's health and social condition; and to the family of the clinic's recommendations, demonstrating treatments and care whenever necessary.

Registration of babies and preschool children with health clinics.

Standard maternity care as recommended by the Maternity Center Association.

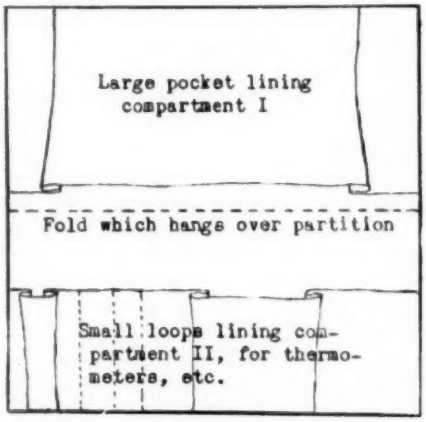
Convalescent care as needed.

Dental care yearly for adults, twice yearly for children.

Immunization for diphtheria, smallpox, and typhoid (when indicated), according to the Board of Health standards.

Reference of all cases of acute illness where prolonged nursing care is needed to Henry Street Visiting Nurse Service, hospitals, etc.

Since only demonstration or emergency bedside care is given, it has seemed unnecessary for the nurses to carry in their bags the complete equipment used by visiting nurse services; and through years of family health work the following type of bag has evolved as being most practical for A.I.C.P. purposes. The aim of carrying enough equipment to insure a technique safe for both patient and nurse was always of first consideration, coupled with a desire to make a bag light and compact so as to eliminate as much of the nurse's fatigue as possible.



A standard brief case—such as can be secured from any local leather manufacturer—is used, in dimension 11¾ inches long, 6 inches high, and 1½ inches wide when empty, stretching when filled to a width of 5 inches. On the outside of the back is a full length pocket used to hold the nurse's field book (containing data on families to be visited, standing orders, routines, local resources, etc.), pen, pencil, and city directory.

The interior of the bag is divided into four compartments. A washable linen lining is provided (easily removable since no snaps are used to hold it in place), which lines one compart-

ment and hangs over the partition to one side of the adjacent compartment, containing at this end small loops to hold the thermometers, soap bottle, etc. The contents of the bag, as found suitable for A.I.C.P. work, are as follows:

COMPARTMENT 1 (starting from back of bag) with linen pocket:
- Apron in washable case (apron made of soft muslin chosen especially for its light weight, folding in a case 7x4 inches).
- Manilla envelope containing cotton.

COMPARTMENT 2 (linen lining along one side):
- 1 ounce bottle containing liquid soap (bottle must have a screw top so that it will not leak if tipped).
- 1 rectal thermometer in hard rubber case.
- 1 mouth thermometer in metal case.
- Manilla envelope containing tongue depressors and applicators.
- Gummed-edged, manilla envelopes for waste (4½x6¾ inches).
- Paper towels.

COMPARTMENT 3:
- Clinic directory.
- Communicable disease booklet of instructions.
- Special health literature.

COMPARTMENT 4:
- A.I.C.P. record forms, cards, etc.

The bag when empty weighs 1¼ pounds; when packed with A.I.C.P. standard equipment it weighs 2½ pounds. The nurses have found it easy to carry as it can either be tucked under the arm or carried by the handle.

FOR PRENATAL VISITS

A.I.C.P. nurses give prenatal care to the expectant mothers in their families. No nurse has enough cases to necessitate carrying prenatal equipment with her every day. Instead she tries to group her cases so as to visit them so far as possible on the same day, at which time she carries a special prenatal bag, as the prenatal equipment does not fit into the brief case comfortably. This bag is similar to the standard square visiting nurse bag, only smaller, being in dimension 12x7x 3¾ inches. It is provided with a removable rubber lining, and is made of a very soft, flexible, lightweight leather so that it can be carried under the arm if desired. Empty it weighs 2 pounds, packed with equipment as listed below it weighs 3½ pounds.

CONTENTS OF THE A.I.C.P. PRENATAL BAG:

Standard A.I.C.P. equipment as listed above, and in addition the following prenatal equipment as recommended by Maternity Center Association:

- 2 test tubes
- 1 test tube brush
- 1 test tube holder
- 1 urinometer
- 1 sterno
- 1 box matches
- Filter paper
- Blood pressure apparatus
- 1 funnel, 1 aluminum cup, Bottle 2% acetic acid, Blue litmus paper — in rubber bag
- 1 thumb forceps
- Blank maternity records

Nurses in other organizations—such as Boards of Health or School Nursing Services—which do not include bedside nursing as a part of their regular daily program, but who, like all public health nurses, must be prepared to meet emergencies and to demonstrate care of the sick when necessary, may find such bags of practical value.

The Summer Round-Up Campaign is proving itself an important factor in educating parents to accept their responsibility for the health supervision of their children. But the Round-Up as a health activity may become a power in enlisting the interest of intelligent parents in a broader community health program. Public health nurses actively coöperating in this project have an unusual opportunity to interpret such a program to this earnest group of public spirited citizens.

Inaugurated in 1925 by the National Congress of Parents and Teachers with 40 units in 21 states, the campaign now enrolls from 2,500 to 3,000 associations in 44 states and the territory of Hawaii. For information, send to national headquarters, 5517 Germantown Avenue, Philadelphia, Pa.

Social Welfare in a Rural County

By Helen E. Gillespie, R.N.
Darke County Health Unit, Greenville, Ohio

IS there a need for organized social work in a rural county? In discussing this perplexing problem, my point of view and the illustrations used are derived from experience as a county public health nurse in such a community.

In order to present a complete picture of the financial resources in the county available for social welfare, the various funds are enumerated, by whom administered, and the approximate sums expended annually. It must, of course, be realized that each fund has been provided by law at various times without any consideration of the other funds.

Hospital finances—directed by hospital trustees. The $6,000 subsidy paid by the County Commissioner, provides free hospital service to indigent cases of the county.

County Home—directed by a special board of trustees. Appropriation, $20,000. Provides care for poor and homeless, capacity 100. Average number of inmates 70.

Children's Home—directed by a special board of trustees. Appropriation $18,000. Provides a home for children without a home or where homes are unsuitable for children. Capacity 42.

Mother's Pensions—granted by the Juvenile Court on the investigation and advice of the probation officer. The purpose is to aid the mother to provide individual instead of institutional home life for the child. There are 89 mothers on our pension list.

Blind Pension—directed by the County Commissioners. Appropriation $10,000. Application is made to the Commissioners, supported by a doctor's certificate. An investigation of these cases is made once a year. There are 73 persons listed who are receiving an average pension of $175 per year. Not a cent of this money is used for sight saving work. Compensation is granted only after the sight is gone.

Fund for Hospital Treatment for Tuberculosis Patients—granted by the County Commissioners. Appropriation $5,000. Application is made to the County Commissioners or to the County Health Department. This treatment must necessarily be outside the county as the county has no sanatorium. At present we have only three patients in sanatoria, although our records at the Health Unit show 91 positive cases, 27 suspicious cases and 359 contacts.

Soldiers' Relief Funds—granted by a committee of three made up of two Civil War veterans and a soldier's widow. The average payment per month is $8.00. This fund is not necessarily restricted to Civil War veterans but has been granted only to this group in this county.

Fund—for expenses of the treatment of crippled children committed through the Juvenile Court.

Briefly, a total of $82,100, for social relief is directed by five different groups. If the amount paid for the support of the Health Unit, which is not primarily a social welfare agency but through which a number of the investigations are made is included, the total sum approximates $100,000 or 40 per cent of the general fund. Besides this, in each township, temporary relief, including fuel and food only, is given to needy cases who have lived in the township for one year.

Outside of Greenville, there is no organized lay welfare work, except sporadic gifts made by churches or fraternal orders to members of their organizations. Thus in most instances county relief must be relied upon entirely.

Two types of public health cases especially, depend upon outside relief: tuberculosis cases and crippled children. This county is essentially rural. There is little stark poverty, such as is often found in urban communities, but

a majority of families have incomes which cannot stand the strain of the cost of medical treatment for the year or more made necessary by either of these types of cases. This is especially the case when the wage earner of the family is concerned. Tuberculosis cases are practically always economic as well as health problems to the entire community.

A SPECIFIC CASE

Let us consider a specific case. First contact with this case was made through children in the school who were very much underweight and undernourished, one being mentally deficient. Investigation revealed the cause of the wretched home conditions to be due partially to the inability of the father to hold even the smallest farm for more than one year. A sputum examination revealed him to be an advanced case of tuberculosis. The finances were inadequate to provide even the poorest makeshift for proper care of a tuberculosis patient. Hospital treatment was advised but the patient refused to consider this as he said his family would starve without even his meager help. The family had not lived in the township a year so township help was impossible. Application was made to the Probation Officer for a Mother's Pension. After his investigation of the home and a report to the Juvenile Court, a pension of $25.00 per month was granted as there were five children. Then application was made to the County Commissioners for hospital treatment for the patient. As no fund provides clothes for patients, the nurse had to secure these through any means she could devise. At last the patient was placed in a sanatorium and the mother left with five children, aged 3 to 12 years, and with the problem of providing and maintaining a home on $25.00 per month. She had one cow, two pigs, and twenty chickens. This admittedly, was a big proposition even for an efficiency expert. During the summer, one of the boys, with a childhood type of tuberculosis, was sent to the State Sanatorium for preventorium treatment. Finding finances too limited, the mother began to increase her income through questionable methods and to neglect the home and children. When the tubercular child was returned, he was placed in the Children's Home. The mental defective was sent to the School for the Feeble Minded. The pension was reduced by the court.

How had the situation been solved? The husband had received a few months of care before his death, one boy had been definitely helped and is under county care; another is maintained by the county in a state institution. Inadequate financial aid is offered by the mother as an excuse for an immoral and neglected home for the three supposedly normal children.

What has this cost? A great deal of the time of the public health nurse has been taken up in social investigation and in reporting to the proper officials; the probation officer has spent considerable time and mileage in investigating the same home; the time of many other officials has been taken in the solution of this one case, besides the money spent from the specific funds.

Suppose there had been a blind person in this same family. Application would have been made to the County Commissioners and a pension granted without any knowledge of any other county aid in the family. Or if one of them had been eligible for Soldier's Relief, this would, no doubt, have been given without any knowledge of other social relief granted to other members of the family. If each agency investigated their pensions at stated intervals, the same home would be investigated by four different people at least. Talking in dollars and cents, if this family lived out 20 miles and a mileage of five cents per mile or even less were allowed to at least three of these investigators and their time considered on the money basis of a mechanic (a dollar an hour or even less), how much has the county paid out for investigation that could be done by one person?

Indigent cases of crippled children are committed to the State Division of

Charities through the Juvenile Court and the cost of hospital treatment is paid by the county. Some cases are refused commitment through lack of understanding of the circumstances of the home. In home investigation a good axiom to remember is one that a well known child psychiatrist often quoted to her classes: "You can't always tell from where you sit."

FOR THESE NO SOLUTION

There are two other types of cases which need help but we have no solution to offer. Unmarried mothers, especially those of school age who need very definite supervision and direction, and the many cases of school children having eye defects and no financial means to provide for corrective measures. The law provides that the school board must furnish books and clothes to pupils not able to attend school because of this lack. Measures corrective of visual defects ought, reasonably, to be included under this provision, as it is wasteful to provide clothing and books for students unable to derive any benefit therefrom because of serious eye defects. We have not had any definite decision on this question.

WHOSE BUSINESS?

Every now and then, when I have had occasion to discuss problems of social welfare pertaining to my work with some fairly large tax-payers they have replied: "I attend to my own business, let other people do the same." But are they attending to their own business? Does not the efficient administration of public funds affect every tax-payer's interests? If $82,100 is spent for social welfare and one-half of this (as estimated by our county auditor) is wasted, whose business is it? Would you invest in any business organization incorporated for $100,000 where the management and supervision of expenditures was divided under five distinct and unrelated heads? Is money invested in taxes any less valuable than that invested in real estate or bonds? Perhaps you are asking, "What do the officials mean by allowing such a waste?" They do not make the laws, they only administer them according to the provisions of the law.

The only conclusion which can be drawn from the conditions presented is that the available funds for social welfare would be much more efficiently and effectively administered if all field work for the various funds were coordinated under one agency. Considerations of economy and efficiency thus indicate the need for organized social welfare work.

I wonder, are we attending to our own business as thoroughly as we think we are?

STAFF FIELD TRIPS

Dorothy Deming, Assistant Editor of THE PUBLIC HEALTH NURSE, made a field trip through the South during March and April in the interests of the magazine. She visited Virginia, South Carolina, Georgia, Alabama and Tennessee and addressed the Public Health Nursing Section of the State Nurses' Association in South Carolina on April 3rd.

Mrs. Violet Hodgson, Assistant Director, has completed a field study of the Visiting Nurse Association of Hartford, Conn.

A field trip was made during January by Mrs. Violet H. Hodgson, Assistant Director. Visits with some eleven industrial nurses were made to the plants in which they were employed. The annual meeting of the New England Industrial Nurses Club was attended in Boston and a talk given at the annual meeting of the Bristol County Branch of the Massachusetts State Graduate Nurses Association on "What Constitutes a Good Tuberculosis Nursing Program."

A conference on the value of social service exchanges was attended by Beatrice Short, Assistant Director, in Rochester, N. Y., on February 16th.

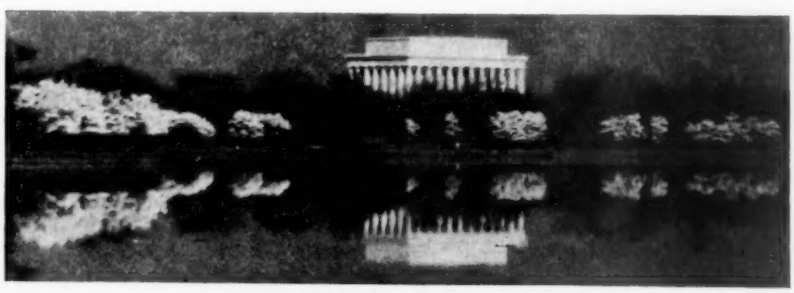
RED CROSS PUBLIC HEALTH NURSING

Edited by ELIZABETH G. FOX

We want to be read: therefore we are closing this department! A "paradox," you say? No, it is quite simple. We have an idea that many of you whose tables are piled with reading matter rejoice when you find something that can be skipped. At least we confess to this weakness ourselves and we rather suspect we have no corner on it. But we have found to our dismay that it is our department which many of you are skipping thinking it intended only for Red Cross public health nurses. This we can scarcely believe, but, alack, it seems to be true. So now in our chagrin that we—WE—should be chosen to be skipped, we are going to play a little trick on you. We are not going to sidetrack ourselves between the fences of a department any more. Not much! We are going to march right out into the body of the magazine without any tell-tale detour sign. And then you will start reading us before you know it, and we are immodest enough to believe that perhaps you will like to keep on to the end.

Elizabeth Gordon Fox

A Red Cross nurse in Vermont—Typical of what Red Cross nurses in a number of northern and western states are called upon to do



Lincoln Memorial in Cherry Blossom Time

Washington has been known to forget to be hot even in June and July! So we venture to invite nurses from abroad to visit Washington before or after the I.C.N. Congress. The most cordial welcome will await you at the headquarters of the American Red Cross and we hope that the weather man will be on his best behavior.

Salaries of Public Health Nurses

Summary Over a Five Year Period—and Current Salaries

By Louise M. Tattershall

Statistician, National Organization for Public Health Nursing

IN the fall of 1924, one of the larger public health nursing associations asked if it would not be possible for the N.O.P.H.N. to collect information about salaries paid to public health nurses throughout the United States and publish it in The Public Health Nurse. In December, 1924, a questionnaire was sent to 23 health departments and 99 public health nursing associations, asking for information on salaries as of November 30th. The report of this information was published in February, 1925.

In 1926 the date for gathering salary information was changed to January 31st, and since that time salary information is as of that date. In 1925 and 1926 information was gathered from health departments and public health nursing associations only. In 1927 it was decided to collect information on salaries paid by boards of education and beginning with this year information is gathered each year from this last group as well as from the other two groups of agencies employing public health nurses.

There is now available for a period of 5 years the salaries paid to public health nurses by health departments and public health nursing associations. The agencies reporting salaries for this period are approximately the same for each year, with the exception of health departments. The number of health departments now reporting each year is between 70 and 85, instead of the 21 reporting in 1925. The number of public health nursing associations reporting each year is between 85 and 106. What, if any, changes have been made in salaries paid to public health nurses in various positions can be discovered in the following table.

TABLE 1. MEDIAN MONTHLY SALARIES PAID BY HEALTH DEPARTMENTS AND PUBLIC HEALTH NURSING ASSOCIATIONS TO PUBLIC HEALTH NURSES EMPLOYED AS DIRECTORS, SUPERVISORS AND FIELD NURSES, OVER A FIVE YEAR PERIOD

January 31, 1929

Year	Directors			Supervisors			Field Nurses		
	All Agencies	Health Depts.	P.H.N. Assns.	All Agencies	Health Depts.	P.H.N. Assns.	All Agencies	Health Depts.	P.H.N. Assns.
1925.....	$210	$200*	$210	$150	$145	$150	$125	$130	$125
1926.....	200	190	215	160	160	155	130	135	125
1927.....	210	190	225	160	175	160	130	135	125
1928.....	210	190	240	160	175	160	135	140	130
1929.....	210	190	250	165	175	160	135	140	130

* Based on 11 agencies.

The seeming decrease in 1926 in the median salaries paid to directors of nursing of both health departments and public health nursing associations and to directors of nursing of health departments, may be disregarded as it is probably due to the small number of health departments reporting in 1925, which made the median salaries for directors of this group too high.

The salaries paid public health nurses in various positions, with the exception of those paid directors of nursing of health departments, are all higher in 1929 than in 1925. The only salaries showing an increase *each year* are those paid to directors of public health nursing associations. The salaries paid supervisors and field nurses show only one or two increases in this five year period.

SALARIES FOR 1929

Information on salaries paid public health nurses has been received from 78 health departments, 133 boards of education, and 99 public health nursing associations. All these agencies with the exception of 33 boards of education employ two or more nurses.

HEALTH DEPARTMENTS AND PUBLIC HEALTH NURSING ASSOCIATIONS

The usual tables are published giving the monthly salaries, tabulated to the nearest $5.00, paid to nurses holding various positions and the number receiving the salary in agencies employing two or more nurses and located in cities of various populations or districts.

The median salaries paid to directors, to supervisors (special and district), and to field nurses in agencies located in cities of certain populations and in agencies employing a certain number of nurses are given in Table 2.

TABLE 2. MEDIAN MONTHLY SALARIES PAID BY HEALTH DEPARTMENTS AND BY PUBLIC HEALTH NURSING ASSOCIATIONS, CLASSIFIED BY POSITION OF NURSE, POPULATION GROUP AND NUMBER OF NURSES EMPLOYED

January 31, 1929

	Directors		Supervisors		Field Nurses	
	Health Depts.	P.H. N. Assns.	Health Depts.	P.H. N. Assns.	Health Depts.	P.H. N. Assns.
All agencies	$210		$165		$135	
For group	$190	$250	$175	$160	$140	$130
Population group						
Cities of						
700,000 or more	260*	375	175	175	140	135
200,000 to 700,000	190	275	160	160	140	125
100,000 to 200,000	190	250	150	150	125	125
50,000 to 100,000	170*	200	140*	150	125	125
25,000 to 50,000	200*	215	†	150	135	125
Less than 25,000	†	200*	†	†	140	135
Number of nurses employed						
50 or more	$210	$345	$175	$165	$150	$135
25 to 49	185*	275	160	160	120	125
10 to 24	190	225	150	150	125	125
2 to 9	175*	200	†	150*	135	125

* Based on less than 10 cases.
† Insufficient number of cases.

SCHOOL NURSES

The report on salaries paid school nurses includes salaries paid by boards of education and by boards of health to nurses employed for full-time school nursing. Table 6 shows the salaries paid to chief or supervising nurses by boards of education only—as in boards of health school nurses are under the chief or supervising nurse of the general division of public health nursing.

The median salary paid by boards of education to chief or supervising nurses is $2,140.

The median salaries paid by both boards of health and boards of education to field nurses giving full-time to school nursing are given in Table 3.

TABLE 3. MEDIAN YEARLY SALARIES PAID BY BOARDS OF EDUCATION AND BY BOARDS OF HEALTH TO FIELD NURSES ENGAGED IN SCHOOL NURSING. CLASSIFIED BY POPULATION GROUP

January 31, 1929

Population group	Median Yearly Salary
All cities	$1,670
700,000 or more	1,830
200,000 to 700,000	1,670
100,000 to 200,000	1,690
50,000 to 100,000	1,560
25,000 to 50,000	1,590
Less than 25,000	1,650

TABLE 4. SALARIES PAID IN SELECTED PUBLIC HEALTH NURSING ASSOCIATIONS CLASSIFIED BY POPULATION GROUP AND BY NUMBER OF FULL-TIME GRADUATE NURSES EMPLOYED

January 31, 1929

Salaries tabulated to nearest $5.00

1. Salaries paid Directors

Monthly salary	Total of all groups	Cities of 700,000 or more: No. receiving specified salary in associations with				Cities of 200,000 to 700,000: No. receiving specified salary in associations with					Cities of 100,000 to 200,000: No. receiving specified salary in associations with					Cities of 50,000 to 100,000: No. receiving specified salary in associations with				Cities of 25,000 to 50,000: No. receiving specified salary in associations with			Cities of less than 25,000: No. receiving specified salary in associations with
		Total	50 or more nurses	25–49 nurses	10–24 nurses	Total	50 or more nurses	25–49 nurses	10–24 nurses	2–9 nurses	Total	50 or more nurses	25–49 nurses	10–24 nurses	2–9 nurses	Total	25–49 nurses	10–24 nurses	2–9 nurses	Total	10–24 nurses	2–9 nurses	2–9 nurses
Total	81	10	8	1	1	18	5	7	5	1	20	1	5	12	2	16	1	9	6	10	3	7	7
$415	5	4	3	1	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..
390	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
375	2	1	1	..	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
355	1	..	..	..	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
335	4	1	1	..	..	2	1	1	..	..	1	1	..	..	..	..	..	..	..	..	..	..	..
315	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
300	9	1	1	..	..	4	2	1	1	..	2	..	1	1	..	1	1	..	..	1	1	..	..
290	1	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..
275	4	..	..	..	..	3	..	2	1	..	1	..	..	1	..	..	..	..	..	..	..	..	..
270	2	..	..	..	..	..	..	..	..	..	1	..	..	1	..	1	..	1	..	..	..	..	..
250	13	..	..	..	..	3	..	2	1	..	6	..	1	4	1	2	..	2	..	2	1	1	..
230	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	1	..
225	4	..	..	..	..	1	..	..	1	..	..	..	..	..	..	2	..	2	..	1	..	1	..
215	2	1	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
210	7	..	..	..	..	1	..	..	1	..	2	..	..	2	..	1	..	..	1	2	..	2	1
205	1	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
200	14	..	..	..	..	1	..	..	..	1	4	..	1	2	1	5	..	3	2	2	1	1	2
190	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	..	..
185	1	..	..	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..
180	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..
175	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..
170	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
165	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	1	1	..	1	..
155	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
150	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1

2. Salaries paid Assistant Directors

Total	43	10	8	2	..	10	4	6	..	..	13	2	3	7	1	6	..	4	2	4	2	2	..
$335	1	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
290	2	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
270	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
260	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
250	5	1	1	..	..	3	3	..	..	..	1	1	..	..	..	..	..	..	..	..	..	..	..
235	3	2	2	..	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
225	2	..	..	..	..	1	..	1	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..
220	1	..	..	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..
215	2	1	1	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
210	1	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..
200	4	1	..	1	..	1	..	1	..	..	2	1	1	..	..	..	..	..	..	..	..	..	..

190	2	..	..	..	..	1	..	1	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..
185	2	..	..	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..

190	2	..	..	..	..	1	..	1	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..	..
185	2	..	..	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..	..	..	1	1	..	..
180	1	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
175	3	..	..	..	..	..	..	..	..	..	2	..	1	..	1	1	..	1	..	..	..	..	..	..
170	1	..	..	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..	..
165	5	..	..	..	..	..	..	..	..	..	2	..	..	2	..	2	..	1	1	1	..	1	..	..
160	4	..	..	..	..	..	..	..	..	..	..	..	..	..	..	2	..	2	1	1	1	..	..	..
155	1	..	..	..	..	1	..	1	..	..	..	..	..	..	..	1	..	..	1	..	..	..	..	..
125	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..

3. Salaries paid Special Supervisors

Total	105	28	20	8	..	39	18	15	6	..	25	4	11	8	2	8	1	5	2	5	5	..	..	..
$290	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
265	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
250	8	7	4	3	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
240	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
235	1	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
230	2	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
225	1	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
215	3	2	2	..	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..
210	2	1	1	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
200	8	1	1	..	..	3	2	1	..	..	3	2	1	..	..	1	..	1	..	..	..	..	..	..
195	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
190	1	..	..	..	..	..	..	..	..	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..
185	9	2	2	..	..	3	2	1	..	..	2	..	2	..	..	2	..	1	1	..	..	..	..	..
180	4	..	..	..	..	3	2	..	1	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..
175	5	..	..	..	..	4	1	3	..	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..
170	1	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
165	6	2	2	..	..	2	2	..	..	..	2	..	1	1	..	..	..	..	..	..	..	..	..	..
160	12	1	..	1	..	8	6	..	2	..	3	..	2	1	..	..	..	..	..	..	..	..	..	..
155	3	..	..	..	..	3	..	3	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
150	16	1	..	1	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
145	8	..	..	..	..	4	1	2	1	..	7	1	2	4	..	4	1	2	1	3	3	..	..	..
140	4	..	..	..	..	4	..	2	2	..	3	..	1	1	1	..	..	..	..	1	1	..	..	..
135	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
125	1	..	..	..	..	..	..	..	..	..	2	..	..	1	1	..	..	..	..	..	..	..	..	..

4. Salaries paid District Supervisors

Total	207	92	87	5	..	61	32	24	5	..	37	11	15	10	1	9	1	8	..	7	5	2	1	..
$250	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
215	5	5	5	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
200	5	5	4	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
195	1	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
190	8	8	8	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
185	11	6	6	..	..	3	1	2	..	..	2	2	..	..	..	..	..	..	..	..	..	..	..	..
180	2	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
175	17	15	14	1	..	1	..	1	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..
170	8	2	2	..	..	4	2	2	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..
165	38	20	19	1	..	12	9	2	1	..	5	..	5	..	..	..	..	..	..	1	..	1	..	..
160	31	8	8	..	..	18	12	5	1	..	2	..	2	..	..	1	..	1	..	..	..	..	..	..
155	8	3	3	..	..	4	2	1	1	..	1	1	..	..	..	3	..	3	..	..	..	..	..	..
150	36	5	5	..	..	12	4	7	1	..	11	3	3	4	1	..	..	..	..	..	..	..	..	..
145	11	2	2	..	..	3	..	2	1	..	4	2	..	2	..	3	..	3	..	5	5	..	..	..
140	16	7	7	..	..	2	1	1	..	..	7	3	1	3	..	1	..	1	..	..	..	..	..	1
135	6	2	..	2	..	2	1	1	..	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..
130	2	..	..	..	..	..	..	..	..	..	2	..	1	1	..	..	..	..	..	1	..	1	..	..
125	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	1	..	..	..	..	..	..	..

Monthly salary	Total of all groups	Cities of 700,000 or more: No. receiving specified salary in associations with				Cities of 200,000 to 700,000: No. receiving specified salary in associations with					Cities of 100,000 to 200,000: No. receiving specified salary in associations with					Cities of 50,000 to 100,000: No. receiving specified salary in associations with				Cities of 25,000 to 50,000: No. receiving specified salary in associations with			Cities of less than 25,000: No. receiving specified salary in associations with
		Total	50 or more nurses	25–49 nurses	10–24 nurses	Total	50 or more nurses	25–49 nurses	10–24 nurses	2–9 nurses	Total	50 or more nurses	25–49 nurses	10–24 nurses	2–9 nurses	Total	25–49 nurses	10–24 nurses	2–9 nurses	Total	10–24 nurses	2–9 nurses	2–9 nurses
5. Salaries paid Field Nurses																							
Total	2,324	884	797	75	12	603	297	203	95	8	521	100	214	205	2	207	30	126	51	84	38	46	25
$165	33	33	32	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
160	71	47	27	20	..	14	..	14	..	..	7	..	1	6	..	3	..	..	3	..	..	..	..
155	44	13	11	2	..	29	29	..	..	..	1	..	..	1	..	1	..	1	..	..	..	..	..
150	232	183	170	13	..	20	6	9	5	..	9	..	1	8	..	3	..	2	1	16	4	12	1
145	75	48	48	..	..	16	16	..	..	..	7	..	1	6	..	2	..	2	..	1	..	1	1
140	228	98	89	6	3	62	44	4	12	2	50	15	23	11	1	13	..	12	1	3	..	3	2
135	362	201	191	7	3	58	33	9	14	2	51	3	36	11	1	31	..	29	2	9	6	3	12
130	207	55	52	..	3	87	34	39	13	1	37	11	10	16	..	17	..	16	1	9	1	8	2
125	484	126	106	17	3	131	62	54	14	1	154	12	61	81	..	51	8	33	10	17	9	8	5
120	146	20	20	..	..	60	22	8	28	2	40	12	20	8	..	15	..	8	7	10	6	4	1
115	156	13	11	2	..	58	24	31	3	..	57	13	29	15	..	21	8	3	10	6	5	1	1
110	164	47	40	7	..	40	13	24	3	..	48	12	17	19	..	23	..	17	6	6	3	3	..
105	31	..	..	..	..	16	12	4	..	..	12	..	12	..	..	3	..	..	3	..	..	..	..
100	63	..	..	..	..	12	2	7	3	..	39	22	3	14	..	10	..	3	7	2	..	2	..
95	2	..	..	..	..	..	..	..	..	..	2	..	..	2	..	..	..	..	..	..	..	..	..
90	11	..	..	..	..	..	..	..	..	..	1	..	..	1	..	8	8	..	..	2	2	..	..
85	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	1	..
80	8	..	..	..	..	..	..	..	..	..	4	..	..	4	..	4	4	..	..	..	..	..	..
75	4	..	..	..	..	..	..	..	..	..	2	..	..	2	..	2	2	..	..	..	..	..	..
70	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	1	..	..
65	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	1	..	..

TABLE 5. SALARIES PAID BY PUBLIC HEALTH NURSING ASSOCIATIONS SERVING COUNTIES OR GROUPS OF TOWNSHIPS

1. Salaries paid Directors

Monthly salary	Total	No. receiving specified salary in associations with: 10–24 nurses	2–9 nurses
Total	5	2	3
$315	2	1	1
275	1	1	..
235	1	..	1
175	1	..	1

2. Salaries paid Field Nurses

Monthly salary	Total	No. receiving specified salary in associations with: 10–24 nurses	2–9 nurses
Total	36	17	19
$165	3	..	3
160	4	3	1
150	12	10	2
145	2	1	1
135	1	..	1
130	2	..	2
125	3	..	3
115	4	3	1
110	3	..	3
100	1	..	1
90	1	..	1

TABLE 6. SALARIES PAID IN SELECTED [illegible]

TABLE 6. SALARIES PAID IN SELECTED HEALTH DEPARTMENTS CLASSIFIED BY POPULATION GROUP AND NUMBER OF FULL-TIME GRADUATE NURSES EMPLOYED

January 31, 1929

Salaries tabulated to nearest $5.00

1. Salaries paid Directors, Superintendents, Supervising or Chief Nurse of Division of Public Health Nursing

Monthly salary	Total for all groups	Cities of 700,000 or more: No. receiving specified salary in health departments with 50 or more nurses	Cities of 200,000 to 700,000: No. receiving specified salary in health departments with				Cities of 100,000 to 200,000: No. receiving specified salary in health departments with				Cities of 50,000 to 100,000: No. receiving specified salary in health departments with			Cities of 25,000 to 50,000: No. receiving specified salary in health departments with			Cities of less than 25,000: No. receiving specified salary in health departments with 2–9 nurses
			Total	50 or more nurses	25–49 nurses	10–24 nurses	2–9 nurses	Total	25–49 nurses	10–24 nurses	2–9 nurses	Total	10–24 nurses	2–9 nurses	Total	10–24 nurses	2–9 nurses	
Total	47	5	17	6	3	7	1	11	4	6	1	7	4	3	5	3	2	2
$540	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
315	1	..	..	..	..	..	..	1	1	..	..	..	..	..	..	..	..	..
300	1	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..
260	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
250	2	..	..	..	..	..	..	2	..	2	..	..	..	..	..	..	..	..
235	2	..	2	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..
230	1	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..
225	1	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..
210	2	..	1	1	..	..	..	1	..	1	..	..	..	..	..	..	..	..
200	6	..	2	..	..	2	..	1	..	1	..	..	..	..	3	2	1	..
190	6	1	3	2	..	1	..	1	..	1	..	..	..	..	1	..	1	..
185	5	1	1	..	1	..	..	..	..	..	..	2	..	2	1	1	..	..
180	1	..	1	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..
175	5	..	3	..	..	2	1	..	..	..	..	1	1	..	..	..	..	1
170	2	..	..	..	..	..	..	1	1	..	..	1	..	1	..	..	..	..
165	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
160	1	..	..	..	..	..	..	..	..	..	..	1	1	..	..	..	..	..
155	2	..	1	1	..	..	..	1	..	..	1	..	..	..	..	..	..	..
150	3	..	..	..	..	..	..	2	2	..	..	1	1	..	..	..	..	..
140	2	..	..	..	..	..	..	1	..	1	..	1	1	..	..	..	..	..

2. Salaries paid Special Supervisors

Total	43	10	18	13	2	3	..	7	5	2	..	6	5	1	2	2	..	..
$250	2	..	..	..	..	..	..	2	2	..	..	..	..	..	..	..	..	..
235	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
225	1	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..
220	5	5	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
200	3	1	..	..	..	..	..	2	2	..	..	..	..	..	..	..	..	..
190	7	..	7	7	..	..	..	..	..	..	..	..	..	..	..	..	..	..
185	1	..	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	..
175	2	..	1	1	..	..	..	1	..	1	..	..	..	..	..	..	..	..
170	1	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..
165	3	2	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..
160	7	..	6	2	2	2	..	..	..	..	..	1	1	..	..	..	..	..
150	4	..	1	..	..	1	..	1	1	..	..	..	..	..	2	2	..	..
140	4	..	..	..	..	..	..	..	..	..	..	4	4	..	..	..	..	..
110	1	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..

Monthly salary	Total for all groups	Cities of 700,000 or more: No. receiving specified salary in health departments with 50 or more nurses	Cities of 200,000 to 700,000: No. receiving specified salary in health departments with: Total	50 or more nurses	25–49 nurses	10–24 nurses	2–9 nurses	Cities of 100,000 to 200,000: No. receiving specified salary in health departments with: Total	25–49 nurses	10–24 nurses	2–9 nurses	Cities of 50,000 to 100,000: No. receiving specified salary in health departments with: Total	10–24 nurses	2–9 nurses	Cities of 25,000 to 50,000: No. receiving specified salary in health departments with: Total	10–24 nurses	2–9 nurses	Cities of less than 25,000: No. receiving specified salary in health departments with 2–9 nurses
3. Salaries paid District Supervisors																			
Total	126	101	16	13	3	..	..	9	6	3	..	..	..	..	..	..	..	..	..
$210	8	8	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
200	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
190	19	17	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
180	6	6	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
175	40	39	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..
170	3	..	3	3	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
165	6	6	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
160	11	2	8	8	..	..	..	1	1	..	..	..	..	..	..	..	..	..	..
150	20	11	3	..	3	..	..	6	4	2	..	..	..	..	..	..	..	..	..
145	4	4	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
140	4	4	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
135	2	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
100	1	..	..	..	..	..	..	1	1	..	..	..	..	..	..	..	..	..	..
4. Salaries paid Field Nurses																			
Total	2,447	1,406	561	272	146	128	15	261	91	156	14	109	59	50	86	36	50	24	
$175	32	..	32	32	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
170	180	180	..	..	..	..	..	..	..	..	..	..	..	..	2	..	2	..	
165	46	..	43	19	24	..	..	1	..	1	..	..	..	..	1	..	1	..	
160	105	85	18	12	..	6	..	..	..	..	..	1	..	1	3	..	3	..	
155	17	..	14	..	14	..	..	..	..	..	..	..	..	..	..	..	..	..	
150	606	410	132	111	10	11	..	25	20	..	5	5	2	3	26	8	18	8	
145	67	35	26	14	5	7	..	..	..	..	..	2	2	..	2	..	2	2	
140	301	193	55	43	8	4	..	29	7	22	..	12	1	11	8	8	..	4	
135	324	200	64	20	10	34	..	34	..	33	1	15	6	9	8	2	6	3	
130	125	47	26	12	6	1	7	32	14	18	..	15	9	6	5	1	4	..	
125	184	101	17	7	3	7	..	26	9	11	6	21	10	11	17	11	6	2	
120	93	18	33	1	19	13	..	37	20	17	..	4	2	2	..	..	..	1	
115	161	96	24	..	5	11	8	13	4	9	..	21	17	4	5	..	5	2	
110	130	41	57	..	42	15	..	19	6	13	..	9	7	2	4	2	2	..	
105	12	..	..	..	..	..	..	12	..	12	..	..	..	..	..	..	..	..	
100	46	..	20	1	..	19	..	21	..	19	2	4	3	1	1	1	..	..	
95	5	..	..	..	..	..	..	..	..	..	..	..	..	..	4	3	1	1	
90	10	..	..	..	..	..	..	9	9	..	..	..	..	..	..	..	..	1	
85	2	..	..	..	..	..	..	2	2	..	..	..	..	..	..	..	..	..	
75	1	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	..	

TABLE 7. SALARIES PAID CHIEF OR SUPERVISING NURSE BY SELECTED BOARDS OF EDUCATION, CLASSIFIED BY NUMBER OF FULL-TIME GRADUATE NURSES EMPLOYED FOR SCHOOL NURSING

January 31, 1929

Yearly salary	Total	Number receiving specified salary under boards of education with: 50 or more nurses	25–49 nurses	10–24 nurses	6–9 nurses	2–5 nurses
Total	31	5	2	7	7	10
$4,000	1	..	1	..	..	..
3,200	3	3	..	..	..	..
3,000	1	1	..	..	..	..
2,700	1	..	..	1	..	..
2,600	1	..	..	..	1	..
2,500	2	..	..	1	..	1
2,400	1	..	..	..	1	..
2,300 to 2,399	1	..	..	..	..	1
2,200 to 2,299	2	1	..	1	..	..
2,100 to 2,199	4	..	..	1	2	1
2,000 to 2,099	4	..	1	1	1	1
1,900 to 1,999	2	..	..	..	..	2
1,800 to 1,899	6	..	..	1	2	3
1,600 to 1,699	1	..	..	..	..	1
1,300	1	.	.	1	..	..

TABLE 8. SALARIES PAID FIELD NURSES ENGAGED IN SCHOOL NURSING BY SELECTED BOARDS OF EDUCATION AND BY SELECTED BOARDS OF HEALTH, CLASSIFIED BY POPULATION GROUP

January 31, 1929

Yearly Salary	Total	Number receiving specified salary under boards of education and boards of health in cities of: 700,000 or or more: Total	B.E.	B.H.	200,000 to 500,000: Total	B.E.	B.H.	100,000 to 200,000: Total	B.E.	B.H.	50,000 to 100,000: Total	B.E.	B.H.	25,000 to 50,000: Total	B.E.	B.H.	Less than 25,000: Total	B.E.	B.H.
Total	1,702	670	174	496	479	293	186	203	108	95	211	194	17	88	78	10	51	48	3
$2,400–$2,499	15	15	15	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2,200– 2,299	3	..	..	..	..	..	..	..	..	..	1	1	..	..	..	..	2	2	..
2,100– 2,199	38	..	..	..	32	..	32	1	1	..	3	3	..	..	..	..	2	2	..
2,000– 2,099	157	124	37	87	9	9	..	17	17	..	3	3	..	2	2	..	2	2	..
1,900– 1,999	109	27	3	24	55	9	46	1	1	..	21	21	..	2	2	..	3	3	..
1,800– 1,899	366	224	5	219	84	82	2	25	9	16	16	16	..	11	7	4	6	6	..
1,700– 1,799	153	67	33	34	21	15	6	28	14	14	19	18	1	13	13	..	5	5	..
1,600– 1,699	302	108	18	90	120	76	44	23	1	22	26	22	4	14	13	1	11	11	..
1,500– 1,599	215	42	13	29	77	52	25	28	24	4	37	37	..	26	22	4	5	5	..
1,400– 1,499	143	48	35	13	26	20	6	28	12	16	23	17	6	13	13	..	5	4	1
1,300– 1,399	104	5	5	..	39	24	15	21	13	8	31	27	4	1	..	1	7	6	1
1,200– 1,299	72	9	9	..	16	6	10	26	11	15	14	12	2	4	4	..	3	2	1
1,100– 1,199	6	..	..	..	..	..	..	2	2	..	4	4	..	..	..	..	..	..	..
1,000– 1,099	13	1	1	..	..	..	..	1	1	..	11	11	..	..	..	..	..	..	..
900– 999	5	..	..	..	..	..	..	2	2	..	2	2	..	1	1	..	..	..	..
800– 899	1	..	..	..	..	..	..	..	..	..	..	..	..	1	1	..	..	..	..

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER

Board Member, Instructive Visiting Nurse Society, Washington, D. C.

INSTITUTES

The first Regional Conference of board members and nurses of the Victorian Order was held in Hamilton, Ontario, on January 15, 1929. Careful preparations preceded the conference. The Districts were circularized, sixteen round table questions bearing on their work were submitted for consideration, and speakers were secured. In spite of the prevalence of influenza, a large number registered. Fifteen of the twenty Western Ontario Associations were represented by 59 board members, 19 nurses and 7 representatives of other organizations. Representatives of the Medical Association of both Provincial and Municipal Health Departments, of local hospitals and social agencies, and of business and political life joined the conference at luncheon, when Major Gibson, President of the Hamilton Victorian Order of Nurses, presided.

At the morning session Dr. Grant Fleming made an appeal for a national point of view, for extension of service to cover opportunities hitherto neglected, and stressed the responsibilities of board members to interpret the work of the Order to the public.

At the Round Table discussion the problems presented included the best type of organization and constitution of the Victorian Order of Nurses boards and committees, ways and means of obtaining good publicity in small districts for development of service and for securing funds, how best to care for chronics, the right basis for promotion and for salary increase, how to provide nursing relief during the night, on Sundays and holidays and for single nurse districts. It was agreed that local branches should be willing to consider adding the cost of central supervision to their Metropolitan Life Insurance Company visits, and, if paid, to turn the difference in to central funds. Each district was invited to appoint an active educational member to the National Education Committee.

At the afternoon session, four short papers on Interlocking Health Services were given from the point of view of the voluntary nursing organization, and the Public Health Department. Medical practitioners, public health officers, and Miss Elizabeth Smellie, the Superintendent of the Order, then joined in a stimulating discussion which brought the day's educational experiment to a successful close. A short play centered about the work of the Victorian Order of Nurses was a pleasant episode in the afternoon session.

The cost of this educational experiment was small and a substantial balance will be applied to the expenses of the next Regional Conference.

Summary of Report made by Dr. Helen R. Y. Reid.

The Visiting Nurse Association of Denver, Colorado, held its first Board Members' Institute—spread over nine days between February 4th and March 4th—with a very comprehensive program, as may be seen from the following:

General Work of the Organization—Superintendent.
Staff Education—Assistant Superintendent.
Our Records—Registrar.
Finances, Present and Future—Treasurer.
Prenatal and Post-Partum Care—Special Supervisor.
Our Relation to Other Social Agencies—Superintendent.
Infant Welfare Work of the Organization—Dr. Forbes, Mrs. Conrad.
Community Chest Relationship—Mr. Guy T. Justis.
Question Box.

The Institute was attended with enthusiasm—untempered by the stern admonition on the program—*Attendance required as in Board Meetings. Excuse to be sent before each meeting to Chairman of Education Committee.* Graduation exercises at the Denver Country Club concluded the Institute, and a Class Play, "The Family and Its Friend" in one act, Time—Any Morning, Place—Typical Home of Patient, was presented. Nine of the board members who had faithfully observed every condition of the Institute were presented with diplomas, with the regulation Gold Seal, which we reproduce.

The Visiting Nurse Association

BOARD MEMBER'S INSTITUTE

Know all men by these presents that the Board of Directors of the Visiting Nurse Association, upon recommendation of the Faculty of its Institute, has conferred upon

.....

Who has fulfilled all the requirements therefor, the degree

Graduate Board Member

With all the rights, honors and privileges, as well as the obligations and responsibilities here and elsewhere appertaining to this degree.

Given in Denver, in the State of Colorado, March eleventh, in the year of our Lord, nineteen hundred twenty nine.

.....
President

.....
Chr. Education Comm.

.....
Superintendent

MIXED BOARDS

In the early part of the winter a request came from a board about to reorganize for an expression of opinion in the Board and Committee Members' Forum as to the value of "mixed boards." The following letters have been received from associations which have both men and women serving on their boards.

A mixed board, we believe, carries with it the possibilities for a better balance when deciding policies, especially those of finance. It makes for a wider range of contacts with other organizations, and perhaps especially with regard to Welfare Federations or Community Funds. We think that mixed boards are very helpful, even though the masculine element may not be as faithful in attendance as the women.—*Visiting Nurse Association, Cleveland, Ohio.*

We started twenty-nine years ago with a mixed board, and our organization has been built up from its very start on this type of management. We feel strongly the desirability of men and women. They bring to every proposition a slightly different and valuable slant.

In pieces of work carried on entirely by women, as are our nursing organizations, as far as the staff goes, it seems wise to have the man's point of view well represented on the governing body. It is also desirable from the publicity end. Our men do a good deal of unconscious publicity work among other men at their clubs, in their business, and as they go about their daily affairs. This brings the organization to a group of citizens who would not otherwise receive the information in so easy and natural a way.

A third reason is that we believe the work to be essentially the community's job—old and

young, men and women should be engaged in carrying it on. We find no difficulty in getting men members for our board, in securing their attendance at meetings, also in getting from them whatever individual work would naturally come within their province. In working with men, however, a little different method is required than in working with women only, but this we believe is a better method and the type of jacking up that they give is exceedingly desirable. They are no less ready to accept an ideal than the women.—*District Nursing Association, Providence, R. I.*

Officially we have a mixed board in this association, but as it is worked out practically the men on the board are active only as consultants. This fact is undoubtedly due to the Community Chest which cares for the deficit of this organization as it does for all the other agencies. Also the location of our central office, which is quite far from the business district, militates against the men being present at our directors' meeting.

I am a firm believer in the advantages of a mixed board for all types of organizations but from my experience, unless there is the need for financial coöperation, I think it is difficult to make the men realize their responsibilities on the social side. We have a lawyer who is a consultant and who was officially a member of the board.—*Visiting Nurse Association, San Francisco, Calif.*

Last year the Sioux City Visiting Nurse Association board was composed of both men and women, but we did not find the mixed board entirely satisfactory. This year we have an active board of fifteen women with an advisory committee of men consisting of three doctors, superintendent of schools, one lawyer and the city health commissioner. The advisory committee can attend all regular meetings and are always invited, but they are not entitled to vote. We find that they are very willing to help in any way they can and have been a great asset to us.

The women are always available for board meetings and are free to give time to drives and other duties. There is always a quorum now to take care of the business while last year it was hard to get a majority of the board members present as the men were too busy to give time to it.

So far this plan has been satisfactory, and the active work of the Visiting Nurse Association is carried on in a more efficient manner.—*Visiting Nurse Association, Sioux City, Iowa.*

(*To be continued*)

The Family Society, by Francis H. McLean, published by the American Association for Organizing Family Social Work (130 East 22nd Street, New York City), an organization which exists for the promotion of local agencies for family work, gives an ideal set-up of a local family welfare society, not only in its relations with other social agencies, including the community chest, but also the interrelations of board members, staff, general secretary and volunteer workers. It should be immensely valuable to all those interested in work of this sort, and contains many suggestions which might be adopted with benefit by board members interested in public welfare.

MRS. JOHN W. DAVIDGE
Instructive Visiting Nurse Society,
Washington, D. C.

A meeting of the Board Members' Manual Committee was held in Washington, D. C., on March 26. The members were very happy to have Miss Katharine Tucker, General Director of the N.O.P.H.N., with them. Material for the second half of the Manual was considered and the committee feels that the work is making good progress.

Communications for this department should be sent to Mrs. G. Brown Miller, care of THE PUBLIC HEALTH NURSE, *370 Seventh Avenue, New York City.*

REVIEWS AND BOOK NOTES

Edited by DOROTHY DEMING

TEACHING HOW TO GET AND USE HUMAN ENERGY

By Thomas D. Wood, M.D., and Marion O. Lerrigo

Public School Publishing Co., Bloomington, Ill. $.75.

This book is intended to be the first of a series (*Teachers' Problems in Health Education*) dealing with the teacher's problems in teaching health. In this book, only two groups of problems are discussed: those dealing with the use of the big muscles for health, and those dealing with nutrition in health education. Later books in the series will include discussion of the problems involved in teaching about fresh air and sunshine; cleanliness; care of the teeth, eyes, ears, nose and throat; clothing; mental health; education for parenthood; temperance education, safety education; protection from communicable diseases; and use of professional health service. There will also be a discussion of problems in the administration of health education. This book used with *Health Behavior* by the same authors should be valuable to all interested in health education.

PUBLIC HEALTH AND HYGIENE

By Charles F. Bolduan, M.D.

W. B. Saunders Company. 1929. Price $2.75.

This new volume by Dr. Bolduan, who is so well known for his useful book on bacteriology for nurses, is dedicated to the memory of Dr. Herman M. Biggs, late Commissioner of Health of the State of New York. This is a well placed tribute to one like Dr. Biggs, "through whose genius scientific discoveries were ever translated into effective administrative measures for the prevention and control of disease."

Dr. Bolduan does not claim originality for his presentation, but the book fills a definite need because it summarizes more complete treatises in print and thus makes accessible to the student of nursing or the college student sources which he would otherwise find difficulty in covering. The author constantly has in mind the need of the student for help in definitions and in cross-references. His chapters on water supply and sewage disposal are excellent summaries. The author covers a large field but does it thoroughly and in a very interesting fashion.

The summary of rules and regulations applicable to the acute communicable diseases will be helpful to students in the field of public health. It is interesting to find a well classified index. Illustrations in the book are full and well chosen. Because of their excellent choice, it is regrettable that the printer should not have done better with some. Any teacher who is looking for a text of this scope would do well to consider this little volume.

R. M. ATWATER, M.D.

A special historical number of *The I.C.N.*, the official publication of the International Council of Nurses, will be ready for the Congress in Montreal. It will be a pleasant and valuable memento of the meeting for visitors to take home with them. It will be convenient at this time to take out subscriptions for *The I.C.N.* and keep ourselves internationally minded. Subscription, by the way, is $1.00 a year. 14 Quai des Eaux Vives, Geneva, Switzerland.

The International Catholic Guild of Nurses has just issued the first number of its official publication, *The Courier*. We wish it all success.

Reginald Berkeley's play *The Lady with a Lamp* can be ordered through the American Nurses' Association, 370 Seventh Avenue, New York, price $1.

A new book on Florence Nightingale has just appeared, by Mary Raymond Shipman Andrews, *A Lost Commander: Florence Nightingale,* published by Doubleday, Doran & Company, price $3.00. A review of this book will appear in our next number.

The March number of the *American Journal of Public Health* contained a special supplement giving a suggested survey schedule and tentative set of standards for the study of Mental and Functional Nervous Diseases, prepared by a sub-committee of the Committee on Administrative Practice of the American Public Health Association. The schedule is presented for criticism and experimental use before final adoption. The introduction states that, in spite of the difficulties inherent in determining standards of care and practice for dealing with problems of mental ill health in a field still unfamiliar to many health officials, a set of standards has at last been created, and an attempt made to set up some sort of a measuring stick by means of which a community may gauge the adequacy of its resources and methods for coping with problems arising out of mental ill health of its citizens. These standards are not of the highest, but neither are they of the lowest. Any community that seriously sets its mind to the task can attain them.

This Survey Schedule can be obtained from the American Public Health Association, 370 Seventh Avenue, New York.

Your Baby's Care, by Dr. Susan P. Souther, is an attractively printed booklet with frequent illustrations, and has the approval of the Medical Advisory Committee of the American Child Health Association and a Committee of the State and Provincial Health Authorities of North America. Its value as a textbook for the mother of the child under two years is enhanced by an index and table of contents. It will be supplied free to nursing associations by the Life Conservation Service of the John Hancock Mutual Life Insurance Company of Boston, Mass. Copies may be obtained after April 25th.

Two very interesting statistical studies have just been completed by Howard Whipple Green of the Cleveland Health Council for the Cleveland Visiting Nurse Association—Analysis of Appointment Nursing Service Experienced, Cleveland Visiting Nurse Association, Year 1928; An Analysis of the Records of the Cleveland Visiting Nurse Association Discharged in January and February, 1928, and Followed Up in July and August, 1928.

A Directory of Clinics and Health Stations in New York City (including the five boroughs) has just been issued which will be of much value to the New York health worker and to the visitor to the city. Copies may be secured from the New York Tuberculosis and Health Association, 244 Madison Avenue, New York. Price 35 cents.

The following new pamphlets are now available for distribution: *Problems in the Prevention and Relief of Heart Disease* and *Heart Disease and School Life.* Sample copies will be sent upon request to the American Heart Association, 370 Seventh Avenue, New York.

So often we are asked about new attractive posters for school room use. Here they are! *Milking Time in Many Lands* is the title of two panel posters published by the Dairyman's League Coöperative Association, 11 West 42nd St., New York City. They are brightly and artistically colored, showing milking time in eight countries. They are especially designed for school room use and are 25 cents each.

The same association has published three new plays: *The Italian Twins and Nona the Goat, How the Alps Got Their Name, The Fountain that Lived*

in the Pitcher. The first two plays may be correlated with history or geography lessons and are suitable for boys and girls from the fourth to the eighth grades. The third may be correlated with English, history, geography and domestic science classes and is suitable for boys and girls from the seventh grade through the second year high school. They are 10 cents a copy.

Pennsylvania has recently published two very valuable handbooks, a Directory of *Statewide Welfare Agencies in Pennsylvania* and *Laws of Pennsylvania Relating to Social Work*. They may be obtained from the Public Charities Association of Pennsylvania, 311 South Juniper St., Philadelphia, Pa. Price 25 cents each. Similar reference books for other states would vastly assist the rural public health nurse as well as her city sisters.

Requests received from educators indicate the need for definite and detailed descriptions of successful school health programs. To assist in meeting this need a study has been made, under the direction of a subcommittee of the Advisory Educational Group of the Metropolitan Insurance Company, of a school health program unique in its growth and possibilities of application in other school systems. It is now published as Monograph No. 5—*A School Health Study of Newton, Massachusetts*. The method of physical examination is described on pages 30 to 34. The children come to the examination without fear and look forward to it as a great event since they have been prepared by the teacher and the school nurse. The examination is made by a competent physician in the presence of the school nurse, the teacher, and often the child's mother.

The Eastman Teaching Films, Inc., are in the process of preparing a series of 16 m.m. safety stock teaching films for junior high school children on such subjects as The Living Cell, Breathing, Circulation, Digestion, Teeth, Posture, Tuberculosis, etc.

Teachers in rural communities have been handicapped in teaching safety because of the lack of pertinent and suitable materials. For the first time information on the rural accident problem as related to the education of the country child has been analyzed and made available in *Safety Education in the Rural School*, recently published by the Education Division of the National Safety Council, 1 Park Avenue, New York City. Price 25 cents.

This manual does not pretend to be inclusive in its treatment of safety education, but suggests topics for safety lessons based on hazards and occupations peculiar to rural districts.

The U. S. Children's Bureau Publication No. 187 concerns *Children in Agriculture*. It presents the results of a study of rural child labor in the United States. Its opening paragraph is arresting:

> On the six and a half million farms of the United States hundreds of thousands of children are at work. Even in midwinter, when almost no farm work is done, the census of 1920 found more than half a million boys and girls from ten to fifteen years old working in agriculture. How many there may be when farm operations are at their height no one knows.

Superintendent of Documents, Government Printing Office, Washington, D. C. Price 25 cents.

The last mystery story intimately connected with the doings and misdoings of the medical and nursing profession we noted was that grand one *Juggernaut*. Here is another—*The Patient in Room 18*, by M. J. Eberhart, sponsored by The Crime Club and published by Doubleday, Doran. The *mise en scene* is not, perhaps, so romantic as the Riviera environment in *Juggernaut*. Events—and such events—take place in a small and hitherto innocent hospital in an American small town setting. Murder, potential villains and villainnesses, a modicum of love interest, radium, and of course the gifted detective, stalk swiftly through its exciting pages. We advise it.

A. M. C.

NEWS NOTES

Mlle. Yvonne Le Rossignol, who holds the three state diplomas of France—those in tuberculosis, hospital, and children's nursing—is expected to attend the Congress of the International Council of Nurses in Montreal. Mlle. Rossignol's coming to the United States is made possible by the Public Health Nurses' Club of Monmouth County, New Jersey, which has offered a scholarship in public health to a graduate of the Bordeaux School. It is hoped that at the time of the International Congress the entire amount of the needed $25,000 for the completion of the School may be presented.

The first International Congress on Air Ambulance Services will be held in Paris from May 15 to 20, 1929, under the patronage of the Queen of the Belgians and the President of the French Republic. A number of countries will send representatives to the Congress. The League of Red Cross Societies will submit a report on "Air Ambulance Services in Peace Time." The following questions will be discussed:

Air ambulance service in connection with field operations.
Air ambulance service in the colonies.
Air ambulance service in the navy.
Air ambulance as a means of evacuating civilians in war time.
Neutrality of ambulance airships in war time.
Physiological conditions regarding transport by air.
Considerations regarding the treatment of sick and seriously injured persons transported by air ambulance.
Peace-time air ambulance service.
Air ambulance equipment.

The Public Health Activities, official and voluntary, have recently been "appraised" in Denver, Colorado, by the Committee on Administrative Practice of the American Public Health Association. While local in application, the recommendations as to public health nursing may be of interest:

That the nursing service of Denver be contralized in two main divisions:

a. School and preschool nursing service (public and private schools). Private school work to be financed by the City Health Department but all school nursing to be under the supervision of one organization.

b. Generalized public health nursing service (Health Department and Visiting Nurse Association).

1. Educational and preventive work financed by Health Department, bedside care financed by Visiting Nurse Association.

2. Superintendent of Nurses responsible to the Health Officer for Health Department work and to the Visiting Nurse Association Board for visiting nurse work.

That any new proposition relating to public health nursing should be considered by a group composed of representatives of the public health nursing organizations.

The Fifth Annual Convention of the International Catholic Guild of Nurses will be held in Montreal July 5–7 immediately before the meeting of the International Council of Nurses. The program takes up the spiritual, social and educational life of nurses, both in hospital and extra-murally. Methods and Problems of Teaching, The Nurse and Social Service, Hourly and Group Nursing, are among the subjects to be considered. Folders giving the Official Itinerary of the Guild to Montreal, and return, can be obtained from the Guild at 124 Thirteenth Street, Milwaukee, Wis.

Miss Elinor D. Gregg is making a field trip in the interests of the nursing department of the Indian service in Arizona and New Mexico.

Miss Gladys Stephenson writes us from China that the first institute for Chinese nurses was held with great

50 DELICIOUS WAYS TO USE KNOX SPARKLING GELATINE IN THE DIABETIC DIET

. . . THE RECIPES contained in the booklet, "Diet in the Treatment of Diabetes," make available a delightful variety of food combinations for the diabetic diet. Because of its recognized purity, and the fact that it is unbleached, unflavored, and free from sugar, Knox Sparkling Gelatine will be found especially valuable in bringing variety, palatability and nourishment to the prescribed diet.

The first part of the booklet carries a reprint of an article from *Modern Hospital,* written by Lulu G. Graves, which discusses the new ideas in diabetic diets. As Miss Graves is Honorary President of the American Dietetic Association, and has specialized in diabetic diets, and has collaborated with leading diabetic authorities, she is well equipped to write advisedly on this all-important subject.

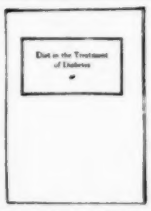
Knox Sparkling Gelatine blends perfectly with the foods commonly used in the diabetic diet, and the increased bulk helps satisfy the constant hunger of the diabetic patient. As each ounce of Knox Sparkling Gelatine contains about 120 calories, the doctor can calculate food formulas exactly. Necessary proteins are added to the diet. Indeed, experiments show that when gelatine is given to humans as the sole source of protein, the waste of body proteins often is reduced by as much as 63.7 per cent (Lusk).

QUALITY WITH ECONOMY

Knox Sparkling Gelatine is the highest quality for health. It is a protein in its purest form, particularly suitable where carbohydrates and acids must be avoided. When you purchase Knox Gelatine you not only get quality but economy, for each package makes four different desserts or salads of six generous servings each.

Additional dietetic booklets available

Listed below are other free booklets which are filled with tempting recipes for using Knox Sparkling Gelatine in the liquid and soft diet of invalids and convalescents, as well as the diet for anemia. A further booklet contains a wealth of data on gelatinated milk as used in child feeding. Check those you wish and mail us the coupon.



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Please send me, without obligation or expense, the booklets which I have marked. Also register my name for future reports on clinical gelatine tests as they are issued.

( ) Diet in the Treatment of Diabetes
( ) Reducing Diet
( ) Varying the Monotony of Liquid and Soft Diets
( ) Recipes for Anemia
( ) Value of Edible Gelatine in Infant and Child Feeding

Name_____ Address_____

City_____ State_____

enthusiasm and success last January. Following a course of lectures on public health, the nurses attending this institute passed a resolution asking the Nurses Association of China to make this a compulsory subject for all schools because of the immediate need of their country.

A good post graduate course, with Miss Anne McCabe, an American nurse, in charge, has been started in Peking. Three of Miss Stephenson's men nurses are now taking a year's course in factory hygiene and allied subjects. The new government is taking a keen interest in public health, posters are stuck up everywhere. "I met a procession the other day, carrying brooms and barrows showing the most needed kind of utensil for street cleaning. All this is helping to educate the public and open the way for health nurses to do their work."

The Nurses Association of China is sending its Secretary, Miss Mary Shih, to represent them at the International Congress of Nurses in Montreal.

The Eighth Annual Convention of the International Society for Crippled Children was held in Minneapolis on March 18, 1929. Dr. Charles A. Prosser of Minneapolis spoke on the rapid development during the last two decades of the movement in behalf of crippled children—"More has been accomplished than in all previous history." Dr. Prosser said there were two steps to take immediately. One is to improve and expand everything which has already been attempted in preventive and restorative surgery, and also in education and employment. The other is to base the work on real equality of opportunity for every citizen.

The convention program dealt with the following general subjects: administration, education and rehabilitation, coördination of all interested agencies, the work of the State and Provincial Societies, rehabilitating the juvenile cripple, the work of public health nurses and teachers of cripples, effective publicity, civic, service and fraternal interests.

The Ninth Annual Meeting of the International Society for Crippled Children will be held in Toronto, Canada, probably in March, 1930. An interim conference will be held in Geneva, Switzerland, beginning July 29, 1929.

NATIONAL MEETINGS

The International Hospital Conference, Atlantic City, N. J., June 13–15. The National League of Nursing Education also meets in Atlantic City June 17–21 at the same time as the American Hospital Association.

National Conference of Social Work, San Francisco, California, June 26 to July 3.

The National Tuberculosis Association, Atlantic City, N. J., May 27–31.

The American Home Economics Association, Boston, Mass., July 1–5.

The Scientific Session of the American Heart Association will be held July 9, 1929, in Portland, Oregon, in the auditorium of the Woman's Club.

The Thirty-third Annual Convention of the National Congress of Parents and Teachers will be held in Washington, D. C., May 5–11, 1929, with headquarters at Hotel Washington.

STATE MEETINGS

The Twenty-second Annual Convention of the Graduate Nurses' Association of Texas, the League of Nursing Education and the Organization for Public Health Nursing will be held in Amarillo, from May 7 to 11. During Public Health Nurses' Day, May 7, Louise Whiteside will speak on "A Model Health Talk to School Children"; Lula Davis, on "Follow-up Visits"; Mrs. Ira L. Caine, on "The Health of the Adolescent"; Dr. P. W. Horn, President of Texas Tech. College, on "The Public Health Nurse's Part in Our Educational Program"; Dr. J. C. Anderson, State Health Officer, on "Public Health in Texas";

Mrs. Myra Cloudman on "Results Gained in a County-wide Demonstration of Public Health Nursing under the Commonwealth Fund"; Dr. G. N. Cultra on "The Health of the Preschool Child"; Rt. Rev. Bishop R. A. Gerken on "The Underprivileged Child."

The New Jersey State Nurses' meetings were held in Jersey City April 18–20. The Public Health session included Round Tables on Rural Public Health Problems, Problems of Board Members, Problems of Staff Nurses, Problems of Industrial Nurses, and Problems of School Nurses. Addresses were given on the following topics: Newer Trends in Child Welfare Work, Mental Hygiene Problems in New Jersey, and Tuberculosis with Special Emphasis on the Disease Among Juveniles.

The Ohio State Nurses Association meetings were held in Cincinnati, April 10–13. The Section on Public Health Nursing discussed the following topics: The Content of a Nurse's Visit to a Tuberculosis Patient, Relation of Industrial Nursing to Public Health Nursing, The Work of a Nurse in Physical Examinations of School Children. Addresses on "Which Makes the Best Nurse for Hourly Nursing—Public Health or Private Duty Nurse?" and "Social Hygiene from the Public Health Nurse's Point of View" were given at other sessions.

The Women's Foundation for Health, with offices at 370 Seventh Avenue, New York, has recently changed its name to "Foundation for Positive Health."

Dr. I. C. Riggin has been appointed Executive Secretary of the American Heart Association, with offices at 370 Seventh Avenue, New York City.

The Michigan Board of Registration of Nurses and Trained Attendants will hold an examination for graduate nurses and trained attendants in Lansing June 6 and 7, 1929, and in Marquette June 26 and 27.

Joint Vocational Service reports the following appointments:

Amy MacOwan will teach Public Health Nursing Classes in the summer session of Emory University, Emory, Ga., after which she will go to Honolulu, T. H., as Educational Supervisor for the Nursing Service of Palama Settlement.

Rose Ehrenfeld, until recently Assistant to the Director of Nursing in the St. Louis, Missouri, Branch Office of the American Red Cross, becomes Director of Health Service in the Community Health and Civic Association in Ardmore, Pennsylvania.

Ruth Cushman, formerly Director of the Ardmore, Pa., Health Service, is making a study of the nursing program of the Babies Hospital, Philadelphia, Pa.

Ruth Fisher to the position of the Supervising Nurse of the Visiting Nurse Association, Plainfield, N. J.

Elsie Horr, formerly of the Cattaraugus County Health Department, New York, becomes Supervising Nurse of the Visiting Nurse Association of New Rochelle, New York.

Clara Peters, formerly in the nursing service for the League of Nations, becomes an Industrial Nurse in the Hotel Commodore, New York City.